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# A STUDY OF CHANGE IN A HOSPITAL:
# THE IMPLEMENTATION OF A UNIT MANAGEMENT SYSTEM

by

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled A STUDY OF CHANGE IN A HOSPITAL: THE IMPLEMENTATION OF A UNIT MANAGEMENT SYSTEM, submitted by Sheila M. Ryan in partial fulfillment of the requirements for the degree of Master of Health Services Administration.

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# ABSTRACT

This thesis focuses on the utility of two theories of formal organizations in providing an understanding of organizational behavior during change. The case study of the implementation of a Unit Management System in four wards in a teaching hospital shows that although bureaucratic characteristics of a hospital are responsible for the stable and dynamic features of the organization, change emerges from a continual bargaining process between individuals, groups, and the organization. Professional nurses defend and extend their positions by coping with both "bureaucracy" and "negotiated order;" and traditional organization structures in the hospital are frequently challenged because of complex relationships and agreements that emerge through negotiations. There is evidence that power in bargaining in the face of change depends upon the strength of personal and professional goals of individuals and groups and that their goals are not necessarily the goals of the organization. The case study demonstrates that Max Weber's theory of bureaucratic organization and the "negotiated order" concept of Strauss and his associates, complement each other in explaining behavior when change hits a traditional organization.

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# CHAPTER I

# THE PROBLEM OF CHANGE

## Introduction

> Change is as inevitable as the morning sun, but neither survival nor growth can be predicted with certainty in managerial circles. Some managers will be required to run as fast as they are able just to keep even, just to hang on the edge of a fast moving, ever-shifting economic order. Some -- only a few, the wisest, most thoroughly trained and most skillful executives -- will be able to outrun the parade, to anticipate the impending changes and thereby make adaptations that lead to growth as well as to survival.[1]

Change seems to be so much the natural order of social life in contemporary society that it is taken for granted. The history of the health care systems is a good example of a history that is based on change stimulated by technology, economic and educational trends and consumers' demands for increased utilization of health care agencies. The growth in the size and complexity of teaching hospitals, for example, is due not only to the general economic growth of the country, but also to the changing demands of a society based on new values about the nature of this kind of health care agency.

Notwithstanding the fact that a teaching hospital operates in a community constantly experiencing change and thus creating

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[1] Rohrer, Hibler, Replogle, Managers for Tomorrow, ed. Charles O. Flory (New York: Mentor Executive Library, The New American Library, 1965), p. 269.

demands for change within the hospital, a hospital administrator faces a basic problem because even when an organizational change is recognized as essential, it is often difficult to achieve the change. Many aspects of the teaching hospital, including value orientations of hospital workers that are founded in history, help to maintain a balance and a continuity during the transition period. The insistence of many members on retaining traditional means, however, tends to create an inertia when changes affect valued assumptions and structures. The tension accompanying change primarily stems from the fact that a particular change may be a satisfactory alternative for one group but oppose the interests and values of another group. Tension may also stem from the fact that members are not prepared for a particular change.

Consequently, it seems that the central question for a hospital administrator is not how to change but how to predict organizational behavior with respect to change. The challenge is to understand not only the structures and processes that are most relevant in the face of an introduction of change but also the extent that resistance may be expected against efforts to alter traditional characteristics of a hospital organization. The ways in which members were involved in the activities related to the implementation of a Unit Management System in the University of Alberta Hospital are, to a large extent, useful in demonstrating the importance of attention to values, social structures, or to processes occurring within these structures when change impinges on and threatens to alter traditional values and control in a teaching hospital.

A review of the literature about the dynamics of organization change reveals a variety of theoretical approaches to the subject of organizational behavior with respect to change. Two theories that offer different viewpoints and interpretations and which include the dynamics of change are the theories of Max Weber[2] and of Anselm Strauss and his associates.[3] The contrast between the theories is vast. Weber's concept is that organization behavior is oriented to sets of rules -- the administrative order -- and that the administrative staff has a dual relationship to these rules. On one hand, the administrative staff's own behavior is regulated by rules and on the other hand, the administrative staff ensures that the rest of the membership adheres to the rules. Furthermore, according to Weber, not only rules but legal authority that depends on beliefs of individuals about the legitimacy of the rule of the law contributes to organization behavior. Strauss stresses that a description of organization behavior in Weberian terms is inadequate; the description must include the actions of the individuals and groups who negotiate and bargain. Strauss demonstrates that members behave according to their personal and professional values rather than to conforming with the administrative order.

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[2] Max Weber, From Max Weber: Essays in Sociology, ed. H.H. Gerth and C.W. Wright Mills (New York: Oxford University Press, 1967), pp. 196-204.

[3] Anselm Strauss, et al, "The Hospital and Its Negotiated Order," in The Hospital in Modern Society, ed. Eliot Friedson (London: The Free Press of Glencoe, The MacMillan Co., 1963), pp. 147-168. Hereinafter, reference to Anselm Strauss and his associates will simply be cited as "Strauss."

## Purpose of the Study

The purpose of this study is to examine the complementary nature of the Weberian and Straussian explanations of organizational behavior with respect to their ability to explain organizational behavior associated with the implementation of a Unit Management System in four wards at the University of Alberta Hospital.

## The Unit Management System: A Brief Description

The Unit Management System has been a controversial topic among nurses and hospital administrators during the last decade.[4] It is an organizational device whereby a person, who is not necessarily a nurse, relieves nurses of non-nursing functions, administrative tasks and coordinating functions at the patient ward level. One justification for the system includes the nursing profession's own criticism about the inappropriateness of the substantial managerial functions presently performed by nurses. It has been proposed that it is a system that not only permits the reallocation of labor so that nurses will be in roles for which they are trained but also maximizes efficient, effective use of nursing personnel and provides

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[4] One of the first programs of a system oriented to delegating functions performed by nurses to administrative staff was introduced in Sinai Hospital in Baltimore. The primary function of a floor manager was to assist the nurse, although he was not part of nursing. The floor manager was trained to "serve nursing." See A Floor Manager Pattern for the Nursing Unit by Gladstein, Prasatek and Thione published by Sinai Hospital of Baltimore, Inc., Baltimore, Maryland, February 1959.

professional care at reduced costs.[5]

A variety of patterns are suggested to accomplish the advantages and functions of a Unit Management System, but there is one basic similarity: persons are employed to relieve nurses of non-nursing functions and responsibilities. The use of such persons in a hospital to perform some work traditionally performed by nurses requires changes in organization structures, roles and relationships for both nursing and supporting personnel. Because these changes require delineation of new role expectations for nurses and a differentiation of roles for proper utilization of the knowledge and skills of nurses, and because these changes may be threatening to the personnel involved, it is useful to consider how an organizational change of this nature was implemented.

## Method of Study

The method used was a case study[6] of the implementation of a Unit Management System in four wards at the University of Alberta

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[5] Norman Brady, J. Herman and G. Warden, "The Unit Manager," Hospital Management, 101:30 (June 1966), p. 32.

[6] Studies concerned with description or exploratory studies that focus on the totality of a particular situation and encourage the researcher to attempt to describe and examine the nature of the interdependence of factors that characterize a social organization of a group have been defined as case studies. According to Goode and Hatt, a case study is a way of organizing social data so as to present the unitary character of the social object being studied. William J. Goode and Paul K. Hatt, Methods in Social Research (New York: McGraw-Hill Book Company, Inc., 1952), p. 331.

Hospital during a period of twelve months. The case study approach[7] was used because it provided detailed information about individuals and groups within a bureaucratic organization and the processes in which they influenced the implementation of an organizational change.

The purpose of the study required information about behavior available only through utilization of a variety of research techniques.[8] These included interviews, participant observation, and analysis of documents.

At the beginning of the year approval was gained for the proposed research from the Executive Director of the Hospital. Initially, the Executive Director and the divisional Directors were interviewed because they occupied the most senior positions in the

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[7] The reliability and validity of the case study approach is defended by scientists who retain the case (a society, social movement, or large-scale bureaucracy) as a unit of analysis. Sjoberg and Nett emphasize that only through a study in depth are the relationships among parts of the system, and between parts and the whole, explicated. Blau points out that the case study method provides opportunity for comparing the reliability of different research techniques and that access to different research techniques improves the accuracy of the data collected as well as their range. See Gideon Sjoberg and Roger Nett, A Methodology for Social Research (New York: Harper and Row, 1968), pp. 257-264; and Peter M. Blau, The Dynamics of Bureaucracy (Chicago: University of Chicago Press, 1963), pp. 3-6.

[8] As Blau says, the case study of a small group has the major advantage of lending itself to interlocking various research procedures and is therefore superior to the interview survey, which is confined to those data that can be obtained from responses to questions. Blau argues that the superiority of the case study to the interview survey, for example, is in the ability of the investigator to obtain precise information about the network of informal relations in a group or the extent to which the competence of an official affects his informal relations or the processes through which his position in the group influences his performance. Blau, op. cit., pp. 4-5.

administrative hierarchy and, as members of the Administrative Committee,[9] recommended to the Executive Director and the Board that they authorize the implementation of the Unit Management System in four wards. These interviews were designed to elicit from respondents clarification of operating practices and social relations in the hospital to determine why and how the Unit Management System was introduced into the hospital. The above respondents were interviewed at the beginning of this study because it was felt that they were in positions "to have observed events" and that they might be "quite perceptive and reflective about them."[10]

Similar interviews were administered during the study to physicians, nurses and other staff members in both the experimental unit and departments related to the unit. Asthe investigation proceeded, in keeping with the concept of Strauss, some subjects were again interviewed because the data indicated they were influential in implementing the new system or, conversely, rejected the concept.

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[9] The Administrative Committee at the University of Alberta Hospital chaired by the Executive Director, consists of five divisional directors each of whom is responsible to the Executive Director, for the administration of one of the five organizational divisions (Medicine, Business Administration, Nursing, Finance, and Manpower). Members meet weekly for discussion about administrative matters brought forward by each divisional director that have implications for the total organization.

[10] The writer was influenced by Whyte who states that best informants are those individuals in key formal or informal positions in a group who not only relate what happened but can provide information on "how that event related to others that took place before and afterwards." In the words of Whyte, the investigator in this study wanted answers to the question: "Who did what, when, with whom, and why? W.F. Whyte, "Interviewing for Organizational Research," <u>Human Organizations</u>, 12 (February 1953), pp. 21-22.

of the Unit Management System and were influential in inhibiting its progress.

Semi-structured, open ended interview protocols were used. The writer divided the interview data into three sections. The first provided an understanding of the values of individuals and groups about roles of nurses, unit managers, and decentralization of responsibility and authority in the nursing organization. The second recorded how alteration of functions of nurses in the experimental unit influenced previous values about roles of nurses and, in turn, how changes in these values affected administrative changes. The third section showed how implementation of the project was modified, vis-a-vis the bureaucratic paradigm, because of negotiations.

The second category of information consisted of observations by the writer. Actions and discussions of individuals and groups were observed and recorded in order to determine the interdependence between information obtained in interviews about organizational behavior and observed practices that depicted organizational behavior. The advantages of this participant observation permitted the investigator to record behavior as it occurred and freed her from depending on respondents' ability or willingness to describe their own actions.[11]

The writer observed activities in the four wards at intervals, during the period of the investigation. Staff members were

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[11] Claire Selltiz, et al., Research Methods in Social Relations (Rev. ed.) (New York: Holt, Rinehart, and Winston, 1959), pp. 201-202.

informed that a study about the Unit Management System was being conducted. Ward conferences, clinics, inservice programs and meetings were attended. There were informal discussions at meal and coffee periods. In addition, the writer attended Administrative Committee and Board meetings at which decisions were made about the Unit Management System. Review of official records and other relevant documents provided additional data.

Interviews and observations were supplemented by the third category of information. Information elicited in interviews and through observations was compared with data provided by a review of documented materials such as minutes of meetings, consultants' reports, memoranda and proposals submitted to members of the Administrative Committee and to members of the Board. Examination of such diverse materials as organization charts, policy and procedure manuals and statements of objectives and philosophies issued by the Department of Nursing Service was also performed for purposes of comparing respondents' information about rules and regulations with that issued by divisional directors.

The investigation focused on issues that emerged as a result of individual and group values about roles of nurses, unit managers, decentralization of administrative responsibilities and authority, and the social processes that influenced the progress of the implementation of the Unit Management System.

## Format

The study is divided into five chapters. Chapter I consists of the introduction, a brief overview of two organizational theories, a brief description of the Unit Management System , the purpose of the study and the method of the study. Chapter II provides a framework of the theories of Weber and of Strauss. Chapter III reviews events leading to the implementation of a Unit Management System in four wards at the University of Alberta Hospital. Chapter IV combines a presentation and analysis of the data related to the implementation of the Unit Management System in four wards. Chapter V, the final chapter, gives a summary, the conclusions, and the limitations of the case study approach.

# CHAPTER II

# TWO ORGANIZATIONAL THEORIES

## Introduction

In his analysis of formal organizations, Weber proposes that modern organizations have developed into bureaucratic types in which authority is based on individuals' beliefs in the supremacy of the rule of law. He demonstrates that rational-legal authority ensures that there is obedience given to the impersonal order of a person in a position of authority within his defined area of legitimate power.[1]

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[1] Weber, in his discussions of power and authority defined power as an individual's ability to carry out his own will despite resistance of others who are participating in the action. See *From Max Weber: Essays in Sociology*, ed. H.H. Gerth and C.W. Wright Mills (New York: Oxford University Press, 1967), p. 180. Conversely, he defined authority as "the probability that certain specific commands (or all commands) from a given source will be obeyed by a given group of persons," because members consider it legitimate for this source to control them. He emphasized that compliance of people in authority relations is voluntary. Furthermore, Weber contrasted rational-legal authority with charismatic authority -- based on orders being justified because of people's identification with a leader's personality -- and with traditional authority -- based on followers' beliefs that orders are justified because it is the way it has always been done.

Peter M. Blau and W.R. Scott bring this out in their discussion about the concept of authority (*Formal Organizations*,[San Francisco: Chandler Publishing Co., 1962]), pp. 27-40.

Other researchers have shown that most organizations reveal all three types of authority patterns. Studies by Etzioni, for example, suggest that hospital organizations rest primarily upon rational and legal grounds but that some leaders will be obeyed because of their charismatic qualities whereas other leaders will exert influence because of the beliefs of individuals and groups in the legitimate rights of persons who have been appointed to positions of authority. Etzioni said that it is difficult to distinguish among modes of authority and that an organization may shift from bureaucratic to charismatic and back to bureaucratic authority. See Amitai Etzioni, *Modern Organizations* (New Jersey: Prentice-Hall, 1946), p. 57.

According to Weber, organizational change occurs because individuals and groups in an organization respond to directions of superiors in the administrative hierarchy. Implicit in this formulation is the assumption that peoples' beliefs about rationality and the rule of the law make possible both the stable and dynamic features of an organization.

Weber's somewhat mechanistic ideal type is accepted to a degree by Strauss who recognizes the significance of Weber's analysis about social processes as they are related to stable features of an organization and to acceptance by individuals of the rule of the law. However, Strauss looks beyond the Weberian perspective and proposes that, because components of a known social order[2] are not binding and shared for all time, and because individuals and groups have personal and professional goals not necessarily in agreement with organizational goals, there is a substantial amount of negotiation and bargaining between members in an organization. Strauss emphasizes that negotiation -- the processes of give-and-take, of diplomacy, of bargaining -- characterizes organizational life.

Furthermore, Strauss proposes that individuals and groups are continually reconstructing the bases of the known social order and the shared beliefs and values upon which it is founded, because

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[2] Social order in an organization (in this case a hospital), according to Strauss consists of combinations of rules, policies, along with agreement, understandings, pacts, contracts and other working arrangements (Anselm Strauss, et al., "The Hospital and Its Negotiated Order," in The Hospital in Modern Society, ed. Eliot Friedson (London: The Free Press of Glencoe, 1963), p. 165).

when they are subjected to pressures for change, such as the introduction of a new technology or a new procedure, these pressures initiate negotiations or re-appraisal with consequent changes in the amount and direction of change. The basic perspective of this viewpoint emerges in its emphasis on organizational behavior being a result of a complex relationship between daily negotiative processes and periodic appraisal processes rather than a result of the rule of the law.[3]

Both theories are discussions about different, but essential and fundamental dimensions of organizational dynamics. The thesis of this study is that they are not opposed to each other but complement each other. Together they contribute more understanding of organizational stability during the implementation of change than would be provided from either theoretical orientation by itself.

## Max Weber's Theory of "Bureaucracy"

Max Weber explores the distribution of power in organizations. He proposes that in a society based on the rule of the law, the dominant characteristics of formal organization are bureaucratic:

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[3] Strauss notes that change, such as the introduction of a new technology or a new procedure, indicates alteration of one or more organizational characteristics may be seen as a threat to integrity rather than as assistance to achieve organizational objectives. Therefore, they suggest that the complex nature of a hospital system requires considerable attention to be directed to values of individuals and groups in various echelons during change. The authors demonstrate that individuals and groups will appraise an innovation that impinges upon or threatens the known social order. They will negotiate and renegotiate as to the degree of change that is acceptable at a given point in time. (Anselm Strauss, _et al._, _op_. _cit_., pp. 164-166.)

> Hierarchical structure of formal authority.
> Hierarchical formal communication networks.
> Division of labour among positions. Tasks are distributed among the various positions of official duties.
> Formally established system of rules and regulations that govern official decisions and actions.
> Formal impersonality of operation.
> Appointments of officials to positions constituting a career.[4]

Weber proposes that bureaucratic organizations function effectively because members obey rules and regulations that determine the authority structure. Obedience to the organization by individuals and groups is in terms of impersonal rules that set up the framework of the organization. Bureaucratic technical superiority over any other form of organization is emphasized by Weber who describes it as:

> Precision, speed, unambiguity, knowledge of files, continuity, discretion, strict subordination, reduction of friction and of material and personal costs -- these are raised to the optimum in the strictly bureaucratic administration.[5]

It would appear that such an organization with its built-in stabilizing devices could well cope with organizational change. First, there are formal mechanisms to reduce an individual's uncertainty: mainly, acceptance of the legitimacy of rules and leadership and explicit contracts by which employees accept influence in prescribed matters from designated leaders who possess legal authority to impose specific rewards and sanctions. Second, the system of formally structured roles negates any ambiguity about who will formulate policy and implement programs.

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[4] Max Weber, _op_. _cit_., pp. 196-204.

[5] _Ibid_., p. 214.

## Limitations of Weberian Theory

The prevalence of problems in contemporary organizations, as well as contrary research findings, have led both laymen and theorists to criticize the Weberian formulation. Robert Merton has suggested, for example, that there are unintended consequences of reliance upon rules that reduce organizational efficiency. He states:

> Conformity to regulations can be dysfunctional both for realizing the objectives of the structure and for various groups in the society which the bureaucracy is intended to service. Regulations are in such cases applied when the circumstances which initially made them functional and effective, have so materially changed that conformity to the rules defeats its purpose.[6]

Another group of critics has suggested Weber's classic analysis does not adequately consider the dynamics of organizational life. These critics emphasize a focus upon members as social individuals and not merely in terms of the formal roles they occupy. Studies by Merton,[7] Gouldner,[8] and Selznick,[9] for example, emphasize that the bureaucratic

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[6] Robert Merton, Social Theory and Social Structure (Illinois: Free Press, Glencoe, 1957), p. 117. This displacement of goals is illustrated when adherence to rules, originally concerned as a means, is thus transferred to an end in itself. For example, the study of the latent function of rules in contrast to their manifest function in a hospital may show that conformity to hospital rules is viewed by nurses as a value rather than as a means to accomplish a specific purpose.

[7] Ibid.

[8] A.W. Gouldner, Patterns of Industrial Bureaucracy (London: Routledge and Kegan Paul, 1965).

[9] Philip Selznick, TVA and the Grass Roots, A Study in the Sociology of Formal Organizations (Berkeley and Los Angeles: University of California Press, 1953).

actions of formal organizations usually ignore the informal relations and values of individuals and groups that lead to unofficial practices in direct conflict with bureaucratic regulations. These findings further elaborate the problems of unintended consequences that disrupt organizations and the values and goals of individuals and groups that modify the formal structure.

Selznick's study, for example, shows that the Weberian description of bureaucracy does not allow for dysfunctions that occur when authority is delegated. On the basis of his study, Selznick suggests delegation of authority that gives various groups power to direct departmental functioning at the same time encourages unintended consequences as a result of differences of interests between each department and between departments and the total organization.

Furthermore, development of departmental goals and values initiates a situation in which individuals identify with their own department rather than with the organization. Careers may appear, therefore, to be best served by conforming with department ideology rather than with overall organizational goals and purposes. Selznick's study further demonstrates that although specialization increases efficiency, the price of such efficiency is an increased division of interests.

The problem of dysfunctions has also been alluded to by Tom Burns and G.M. Stalker. In a report on twenty studies in England and Scotland that centered on attempts of traditional firms to absorb research and development engineers into their organizations, Burns

and Stalker suggest traditional forms of organization are not always adequate in the face of change.[10] These studies describe individuals in traditional firms as being committed both to organizational goals and to group and departmental interests to which their careers are tied. Burns and Stalker suggest that, in the face of change, power struggles between departments to gain control of new functions and resources perpetuate traditional organization structure and prevent an organizational change that would introduce specialists into the firm.

## The "Negotiated Order" Theory of Anselm Strauss and His Associates

Strauss offers a way of understanding interpersonal dynamics in the face of organizational change that is in the tradition of the above critics of bureaucratic theory. He reflects the essence of this school of critics when he suggests the means to organizational change is to a substantial degree in the hands of those who are able to negotiate effectively.

To a considerable degree Strauss has synthesized these criticisms with his concept of a "negotiated order" model for viewing organizations.[11] His focus is on interpersonal dynamics in an

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[10] Tom Burns, G.M. Stalker, The Management of Innovation (London: Tavistock Publications Ltd., 1961).

[11] Anselm Strauss, et al., "The Hospital and Its Negotiated Order," in The Hospital In Modern Society, ed. Eliot Friedson (London: The Free Press of Glencoe, 1963), pp. 147-168.

organization under the impact of both internal and external pressures for change. According to Strauss, change is a continuous, on-going process because any change in the social order in an organization initiates grounds for negotiations and these negotiations cause further reconstruction of the bases of social order as individuals and groups review, revise and renew informal agreements, contracts and understandings. As Strauss remarks, the informal bases of concerted action (social order) are reconstituted continually, or "worked at"[12] and the consequent changes as a result of negotiative processes supplement and modify formal directives and programs regarding change.

It must be stressed that Strauss recognizes the value of a more systematic view of formal organizational dynamics and agrees that structural attributes contribute to organizational stability.[13] He suggests, however, individual and group goals do not necessarily always agree with organizational goals and that the traditional, legitimated, formalized organization structure is therefore challenged frequently. He says values of individuals and groups have crucial

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[12] Ibid., p. 148.

[13] The point Strauss and his associates emphasize is that, because the goal enunciated by the formal organization is shared by members, organizational behavior is, to a degree, in terms of organizational response to organizational purpose. They state the organizational goal is the symbolic cement that metaphorically speaking holds the organization together. For example, they state all personnel in a hospital share the common institutional goal -- to provide patient care -- and other goals of individuals and groups are not given explicit, verbal precedence. Strauss, et al., op. cit., p. 154.

significance in organizations subject to change.[14]

Strauss also recognizes that rules govern actions of individuals and groups[15] but points out that because they often are not clearly stated or binding, they also contribute to the phenomena of negotiation. He comments:

> Rules fail to be universal prescriptions: they always require judgement concerning their applicability to the specific case.[16]

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[14] Values of individuals and groups are utilized in general justification of performances within an organization. Because different kinds of training influence ideological positions, professionals in a hospital have different values about treatment of patients and consequently devise different programs of patient care. Furthermore, in a division of labor who works with whom -- and how -- depends to a considerable degree upon the ideology members adopt as well as hierarchical positions they occupy. Members in different echelons develop points of view that are utilized to justify their autonomy within the system. Thus, as Strauss and his associates demonstrate, the services of a social worker will not be used by all physicians, while each physician who does utilize her services does so differently. Non-professionals also have beliefs about how patient care should be provided. Allegiance to these beliefs creates disagreements between nurses and aides, for example, and as a result aides negotiate with nurses in order to arrive at agreements to implement their notions. Patients reflect local attitudes and interest about kinds of treatment and care they should receive and contribute to alteration of organizational policies of the hospital in this respect. Strauss and his associates emphasize the pursuit of individual and group idealogical and personal interests lead people to involve the organization in negotiation and bargaining with the formal bureaucratized administration of the hospital over the management of patient care. Strauss, *op. cit.*, pp. 150-151.

[15] Strauss and his associates state policies and rules serve to set the limits and some of the direction of negotiation. This proposition is implicit in their discussions about rules, negotiation and the patterning of negotiation when they document that not only do personnel call upon the resources of the rules of the hospital to obtain what they themselves wish but also, on the other hand, are inhibited to strike bargains for agreements or actions because of a set of rules that restrict negotiation. Strauss, *op. cit.*, pp. 151-154.

[16] *Ibid.*, p. 153.

Because judgement is always necessary and because of the multiplicity of purposes found in an organization such as a hospital, the following of rules can be very complex. These matters are further complicated because professional associations and unions introduce another set of rules that influence members of the organization. These factors stimulate a great deal of negotiation about not only means but also ends as defined by the bureaucratic hierarchy.[17]

The processes of negotiation result in agreements between individuals and groups with a variety of ideological commitments and in a variety of hierarchical positions. Although some agreements are explicit and specific, others are implicit and tacit understandings between personnel. What is important about such agreements is that they often have a temporal aspect and it is understood between the parties involved that there is a more or less specific period. In addition to this temporal aspect, Strauss demonstrates agreements do not occur by chance nor are they established between random parties. There is a patterned variability of negotiation pertaining to who contracts with whom about what, as well as when agreements are

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[17] The inherent tendency to negotiate and bargain is promoted by the interdependence of daily working arrangements and the more permanent structures as personnel attempt to accomplish their individual purposes while working toward institutional objectives. Not only does interdependence promote negotiation and bargaining, but, as Strauss and his associates demonstrate, because a large number of contingencies lie outside the rules,much of the action in a hospital is not ruled but must be agreed upon. Strauss, *op. cit.*, p. 156.

made.[18] Accordingly, any understanding of organizational dynamics during implementation of a change, such as Unit Management Systems, must also take into account the complex relationships and agreements that emerge through negotiation.

In overview, Strauss suggests negotiation results in informal compromises and agreements that modify intentions; it occurs predictably and exists as a continuum running from specific to non-specific termination dates. He also states agreements are subject to review and to withdrawal at any time so that organizational behavior is conditional and temporary according to the frequency and impact of periodic appraisals.

## Limitations of the Theory of Negotiated Order

Strauss, in emphasizing the concept of "negotiated order," as a basis for change, attached great significance to the influence of personal and professional values in influencing the rate and direction of changes in an organization.

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[18] According to Strauss and his associates, physicians and nurses execute the design of this changing pattern of negotiation. Thus, physicians and nurses attached to each ward reach certain kinds of understandings and agreements which neither tend to establish with any other type of personnel. The intrusion of a new physician, or a physician who wishes to establish a different kind of program in a ward, initiates negotiative activity, the result of which is that nurses negotiating with more senior administrative personnel for support and increased power make new contracts. The changing pattern of negotiation between organizational members is influenced by hierarchical positions, ideological commitments and intervals, at which personnel are rotated on and off the wards. Strauss, *op. cit.*, pp. 161-164.

Although he agrees that secondary relations, rules and formal structural attributes contribute to organizational stability, he does not clearly delineate the significance of such mechanisms for change. Furthermore, he does not demonstrate that during the implementation of change, Weberian bureaucratic principles have considerable significance in explaining organizational behavior.[19] Neither does he explicitly discuss the extent to which Weberian explanations of organizational behavior complements the concept of "negotiated order."

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[19] This aspect is illustrated by Peter Blau in his study of Bureaucracy in Modern Society. He documents evidence of alignment of members with values about disciplined obedience in the organizational hierarchy of authority that shows the implementation of social change depends on the application of Weberian principles of rationalistic bureaucracy. As an illustration,he states the deliberate introduction of a social innovation whether it involves the production of a new weapon or the enforcement of a new law, occurs as members respond to bureaucratic methods of administration. He suggests that the implementation of social change is often bureaucratically instituted. Peter M. Blau, Bureaucracy in Modern Society (Toronto: Random House, 1956), pp. 91-96.

# CHAPTER III

# EVENTS LEADING TO IMPLEMENTATION OF A UNIT MANAGEMENT SYSTEM PROJECT

## Introduction

In September 1969, a Unit Management System project was implemented in four wards at the University of Alberta Hospital. The historical conditions that gave rise to this system of ward management and the factors that supported it can be traced back to the years after World War II when the character of the hospital began to change rapidly. Medical research accelerated and introduced new services and departments, causing the size and complexity of the hospital to increase.

Growth of medical, nursing and administrative functions was paralleled by development of a variety of occupational groups. These included certified nursing aides, nursing orderlies, technicians, technologists and ward clerks. The development of these groups increased the numbers of people employed in the hospital and contributed to an increased complexity in the division of labor. Increased centralization of services and departments led to increased bureaucratic characteristics in the organization as efforts were made to meet responsibilities of teaching, research and patient care. In the Department of Nursing, nurses began to perform different kinds of tasks and procedures because of the advances in medical technology and therapeutic methods. Furthermore, new drugs, advanced medical

and surgical procedures and complicated machinery were introduced on wards.

Because of social changes since the war, nurses employed at the hospital also found themselves in the midst of dramatic changes in nursing practices and procedures. For example, newer attitudes toward further education were reflected in changes in patterns of nursing education and nurses began to be differentiated on the basis of education, as nurses from university schools and independent schools were employed at the hospital.

Nurses with different orientations to values about the nurse's role in meeting patients' psychological and physical needs questioned the traditional system of nursing in the hospital. They were educated to believe nursing should involve more than the performance of procedures and overt technical operations. They described the role of the nurse as one that should involve a process of interaction between the nurse and the patient in which the nurse assists a patient to cope with anxieties and fears. They pursued ways to revise the traditional system of nursing.

In the early days of the hospital, nursing functions consisted of ministering to and comforting patients, and performing housekeeping tasks. In recent years there was an emphasis upon nursing specialization, organization and management of increased nursing service workloads and an acceptance of managerial functions. Writing requisitions, checking supplies and coordinating functions of other staff in other departments were some of the activities that occupied nurses. Nursing

aides and nursing orderlies were assigned many tasks previously performed by nurses, but the numbers of registered nurses required to cope with technical, managerial and supervisory functions continued to increase.

A manifestation of changes in roles of nurses was described by a University of Alberta physician as the retreat from the patient.[1] He said the nurse, with her battery of flashing lights, microphones and intercoms ensconced behind a glass-partitioned desk removed from her patient, was reminiscent of a gunnery officer at his control station firing at an unseen foe! According to Dr. Greenhill, although the nurse in white was still the symbol of understanding, sympathy and comfort to those who were sick or in pain, more and more of these attributes were being usurped by girls in uniforms other than white.

In Alberta this physician's concern about nurses' retreat from patients and changes in their traditional role was paralleled by hospital administrators' concern in 1964 when the Alberta Association of Registered Nurses began using collective bargaining to negotiate for higher salaries, fringe benefits and better conditions of work.[2]

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[1] Stanley Greenhill, "Our Changing Society," Canadian Nurse, 56 (May 1961), p. 408.

[2] Previously, the Executive of the Alberta Hospital Association had held joint meetings with the Executive of the Alberta Association of Registered Nurses that resulted in mutual agreements about salary increments for professional nurses employed in hospitals. In 1962, as a result of nurses' complaints about difficulties in employer-employee relations, a resolution was passed at the Annual Meeting of the Alberta Association of Registered Nurses that staff associations should be formed for the purpose of providing a voice for nurses.

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Hospital administrators began to feel many pressures that demanded alteration in the old order, but the most disturbing force came from nurses as they entered a new phase of development, reflecting new cultural values about their responsibilities and privileges. Although they still had an altruistic philosophy about the quality of nursing service to be rendered to society, nurses now demanded not only increased salaries but also improved working conditions. At the University of Alberta Hospital, it seemed that if their demands would not be met, nurses would resign to search elsewhere for situations that might better meet their preferences.

Respondents gave the writer different explanations for the fact that, despite increasing rates of salaries, it was difficult to recruit and retain nurses at the hospital, particularly during the summer months. The Business Administrator blamed part of the problem on Edmonton's geographic position, which offered fewer attractions than other centers for younger nurses because of its isolation, harsh

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Footnote #2, continued:
In 1964, the Alberta Association of Registered Nurses presented recommendations for an increase of $60 over the monthly salary of $300 as a starting salary for a general duty graduate nurse, and for recognition for experience and preparation in nursing. Negotiations were not successful. The Alberta Association of Registered Nurses accepted an increase of $30 per month as a starting salary for a general duty nurse. In 1965, a hospital staff nurses' association was certified as a bargaining unit under the Labour Act. The University of Alberta Hospital and its staff nurses' association joined three other Edmonton hospitals for a collective bargaining process in which the Alberta Association of Registered Nurses and the Alberta Hospital Association acted as bargaining agents for their members within the concept of group bargaining. For further details, see George P. Van, "Nurse Group Bargaining Gains Ground in Alberta," Hospital Administration in Canada, 9 (February 1967), pp. 37-38.

climate and limited facilities for entertainment.[3] A physician criticized administrative policies and management. He said there was an inadequate number of nurses employed to carry out complex patient care required in the contemporary situation. He said resources were allocated according to the number of beds rather than according to the degree of illness and needs of patients. He complained about the amount of nurses' time spent with administrative tasks rather than nursing care.[4]

The Director of Nursing said she believed the high turnover of nurses was due to such factors as pregnancy, illness of children, transfers of husbands, and school children's vacations. She suggested another contribution to the shortage of nursing was the removal of student nurses from providing nursing service in many areas.[5]

The signs of organized nursing's economic objectives became apparent. Just as apparent was that the hospital could not afford to have nurses performing many tasks that occupied them. The point

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[3] Interview with the Business Administrator, February 10, 1970.

[4] Interview with a physician, April 14, 1970.

[5] A 44-hour week was instituted for student nurses in 1963 and in February 1965 student nurses were granted a 40-hour week. In March 1968 a memo to the Director of Nursing from the Coordinator of Nursing Education estimated the utilization of student nurses for the provision of nursing services in a comparison to the percentage of time spent in education by each category of student nurses was:

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|---|---|---|
| Junior Students | 95% (education) | 5% (nursing service) |
| Intermediate Students | 25% (education) | 75% (nursing service) |
| Senior Students | 10% (education) | 90% (nursing service) |

Memo from Coordinator of Nursing Education to Director of Nursing and to the Accountant, March 16, 1968.

was emphasized by a hospital administrator early in 1967 when he wrote:

> If a nurse of today complains that she is drawn from the bedside, that she is not achieving the objectives of total patient care which attracted her to nursing, she must realize, and her leaders must realize, that in driving toward their economic goals, the nurse will be farther and farther from the bedside -- at least in the same sense of what is constituted as traditional bedside care.[6]

The above administrator also said economic necessity would dictate graduate nurses were too expensive to perform tasks that auxiliary personnel could perform. Nurses should be utilized at a level of employment indicated by their salary demands.[7]

Another force that began to have weight in the last decade was governmental demand that traditional systems of patient care in the hospital be altered in the interests of efficiency and effectiveness. The concept of efficiency and effectiveness is an elusive one but rising costs forced a new focus upon cost control. Administrative personnel were faced with the challenge of utilizing labor and capital efficiently to produce the level of patient care demanded within the framework of the economy.

Problems that accompanied economic and social changes in nursing and that faced hospital administrators are reflected by Everett C. Hughes who wrote in a forward to Aileen Ross' sociological inquiry into the process of becoming a nurse:

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[6] R.B. Ferguson, "Is the $10,000 Nurse Around the Corner?" Hospital Administration in Canada, 9 (February 1967), p. 31.

[7] Ibid.

> Some may yearn for the day when a nurse never talked back to her elders or better, including physicians, and took thought neither for the number of hours she worked nor the slimness of her pay envelope. They yearn partly for a myth and wholly in vain.[8]

Factors contributing to a disruptive force in the University of Alberta Hospital by 1967 were conflict between nurses' traditional values and newly emerging values about nursing, intensity of patient care and changes in nursing roles. In fact, the incongruity between nursing functions and roles and professional nursing value patterns was the basic sociological factor that gave rise to a crisis in the Department of Nursing in the summer of 1967.

Because of a continued nursing shortage, beds for patients with medical and surgical conditions were closed. Discussions by members of both the Administrative Committee and the Board led to a recognition that there was need to examine alternative forms of organization patterns in the Department of Nursing. Previous discussions had not resulted in action because many people found it difficult to visualize unknown systems offering benefits that could be better than the older systems. At this time, the Director of Nursing and the Assistant Business Administrator were requested to review literature and search for information about Unit Management System programs.[9]

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[8] Aileen Ross, Becoming a Nurse (Toronto: The Macmillan Company of Canada Ltd., 1961), p. viii.

[9] Since her appointment in 1960, the Director of Nursing proposed to the members of the Board and of the Administrative Committee the need for the separation of non-nursing functions from nursing functions. A brief submitted by a Nursing Core Committee in 1967, containing recommendations for the new Centennial Hospital,proposed that Unit Managers responsible for management functions should be employed.

The most important development that arose from the crisis was the Board's decision to employ consultants to study the situation in the Department of Nursing and identify factors influencing the shortage of nurses over which there might be administrative control.[10]

## Nursing Activity Study

Due to recommendations by the consultants, a Nursing Activity Study was conducted to identify ways to optimize utilization of staff in the Department of Nursing and to minimize utilization of nursing staff in the performance of non-nursing activities. In the context of the activity study, the nursing team was considered to include charge nurses, assistant charge nurses, team leaders, registered nurses, certified nursing aides, student nurses, nursing orderlies, and ward clerks. These staff members amounted to 45 percent of the total hospital work force accounting for $4.6 million annually in salary expenditures.[11]

A work sampling exercise was carried on in fourteen wards to provide information about tasks performed by nursing staff. Interpreted as being representative of all nurses at the hospital, it showed time spent on clerical duties ranged from 28 percent of assistant charge nurses' time to 13 percent of student nurses' time. Charge nurses spent between 8.6 percent and 10.6 percent of their time with

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[10] Kates, Peat, Marwick and Co., in November 1967 reviewed the organization, policies and practices and related affairs of the Department of Nursing.

[11] Report of A Nursing Activity Study at the University of Alberta Hospital, January 1969, p. 1.

patients; 30 percent of their time was spent at the desk on the wards. The average amount of time for direct nursing care spent by all categories of nursing staff was 33.3 percent. There was little variation in the kinds of tasks performed by general duty nurses and student nurses. Members of the study team did not attempt to assess the factor of quality nursing care; the study provided only quantitative information about utilization of nursing staff, confirming opinions that many nurses spent little time giving direct nursing care.

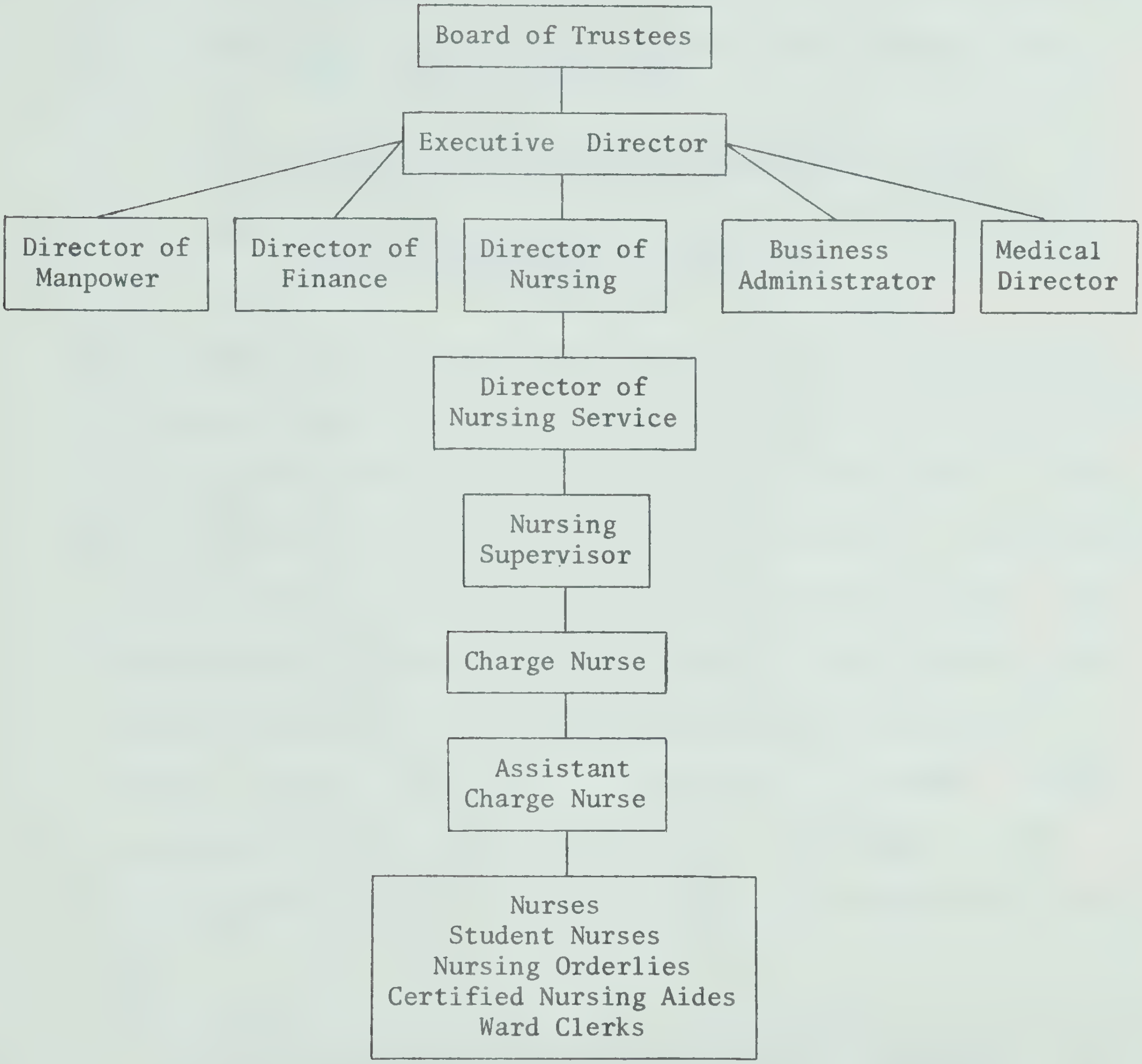
Included in the Nursing Activity Study was an examination of the organizational structure of the Department of Nursing and a description of functions that occupied nursing staff. The organization chart at the University of Alberta Hospital shows the centralized control character of the hospital (see Chart I). Through an elaborate chain of command, employees are directly or indirectly responsible to five divisional directors, each of whom is responsible for the administration of a division of the organization to the Executive Director and thus to the Hospital Board.

The five Divisional Directors (Manpower, Finance, Nursing, Business Administration and Medicine) are members of a group described by the Executive Director of the University of Alberta Hospital as the cabinet of the administration. This Administrative Committee acts as an advisory body to the Executive Director and to the Board. The Committee serves to:

(1) Maintain effective communication among Divisional Directors;

CHART I

Organization Chart
THE UNIVERSITY OF ALBERTA HOSPITAL
DEPARTMENT OF NURSING SERVICE



(2) Enable Divisional Directors to arrive at a consensus and develop recommendations to be presented to the Executive Director and the Board;

(3) Review supra divisional issues that cannot be decided by one Divisional Director;

(4) Advise each Divisional Director about administrative action he should consider;

(5) Discuss proposals submitted by Department Heads, Medical Staff and other individuals and groups;

(6) Develop objectives within the framework of the philosophy of management by objectives.

Formal communication to Department Heads from Divisional Directors is by directives, memoranda and letters. Information may also be published in the hospital newsletter and the medical staff newsletter. It may also be relayed at a weekly Department Heads' meeting. In the Division of Nursing, the Director of Nursing is the Divisional Director. She delegates the management of the Department of Nursing Service to the Director of Nursing Service. Nursing supervisors, responsible to the Director of Nursing Service for the management of a number of wards, are assisted by Charge Nurses each of whom is in charge of a ward. Nursing staff are responsible for maintaining wards twenty-four hours daily.

The study team pointed out that although a Charge Nurse occupied a position of administrator and manager, the position did not carry with it formal authority commensurate with its responsibilities. The team stated that many nurses were paid salaries based upon their skills and preparation as nurses when in fact they performed many functions that could be accomplished by other people with different

preparation. The roles of Assistant Charge Nurses and Team Leaders were described as ill-defined and without specific responsibilities.

The study team proposed that a Unit Management System providing wards with administrative services might enable nurses to give more nursing care. The team proposed that a Unit Management System project should be implemented in two or three wards. Nurses responsible for nursing functions would work with a Unit Manager who would be responsible for coordinating non-nursing functions.

After the release of the results of the Nursing Activity Study, on March 20, 1969 the University of Alberta Hospital Board authorized the commencement of a Unit Management System project. The Coordinator of Management Centers[12] was delegated to direct and implement a Unit Management System. A Nursing Coordinator would be appointed by the Director of Nursing to implement changes in nursing, and to liaise with the Coordinator of Management Centers -- the Project Director.

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[12] The consultant's report to the Hospital Board related to organizational structure of the University Hospital in 1968, recommended that a position of Coordinator of Management Centers should be created, and that the individual appointed to the position would be directly responsible to the Business Administrator. Responsibility of the position was described as developing and initiating a system of Ward Management Services within the existing University Hospital and the new Centennial Hospital presently in the design state, directed towards establishing administrative services to patient-care areas.

On December 30, 1968, Directors of Divisions, and Heads of Departments in the Hospital were notified by the Business Administrator that the Work Study Officer who had directed the Nursing Activity Study had been appointed to fill the position.

## First Proposal by the Project Director

Early in May of 1969, the Project Director submitted proposals to members of the Administrative Committee. According to him, the first objective of the Unit Management System was to correct the administrative and nursing organization to permit a more effective utilization of staff and services. He also said:

> Its inception must have a cost basis and this lies in the improvement of patient care at a minimal cost, or the reduction of cost by eliminating nursing positions without any change in patient care standards.[13]

The Project Director recommended that the position of Unit Manager in the Division of Business Administration should be placed at the same hierarchical level as the Supervisor in the Division of Nursing (see Chart II). The Unit Manager was described as a coordinator between service departments and nursing staff. His functions were stated to be those of implementing systems, including preparation and control of budgets, staffing, equipment and supply and delivery services.

The proposal initiated conflict and some opposition as members of the Administrative Committee examined the implications of the system. The Director of Nursing said a Unit Manager should not be in a position that was removed from a Charge Nurse position. In her view, a Unit Manager worked with a Charge Nurse performing administrative and

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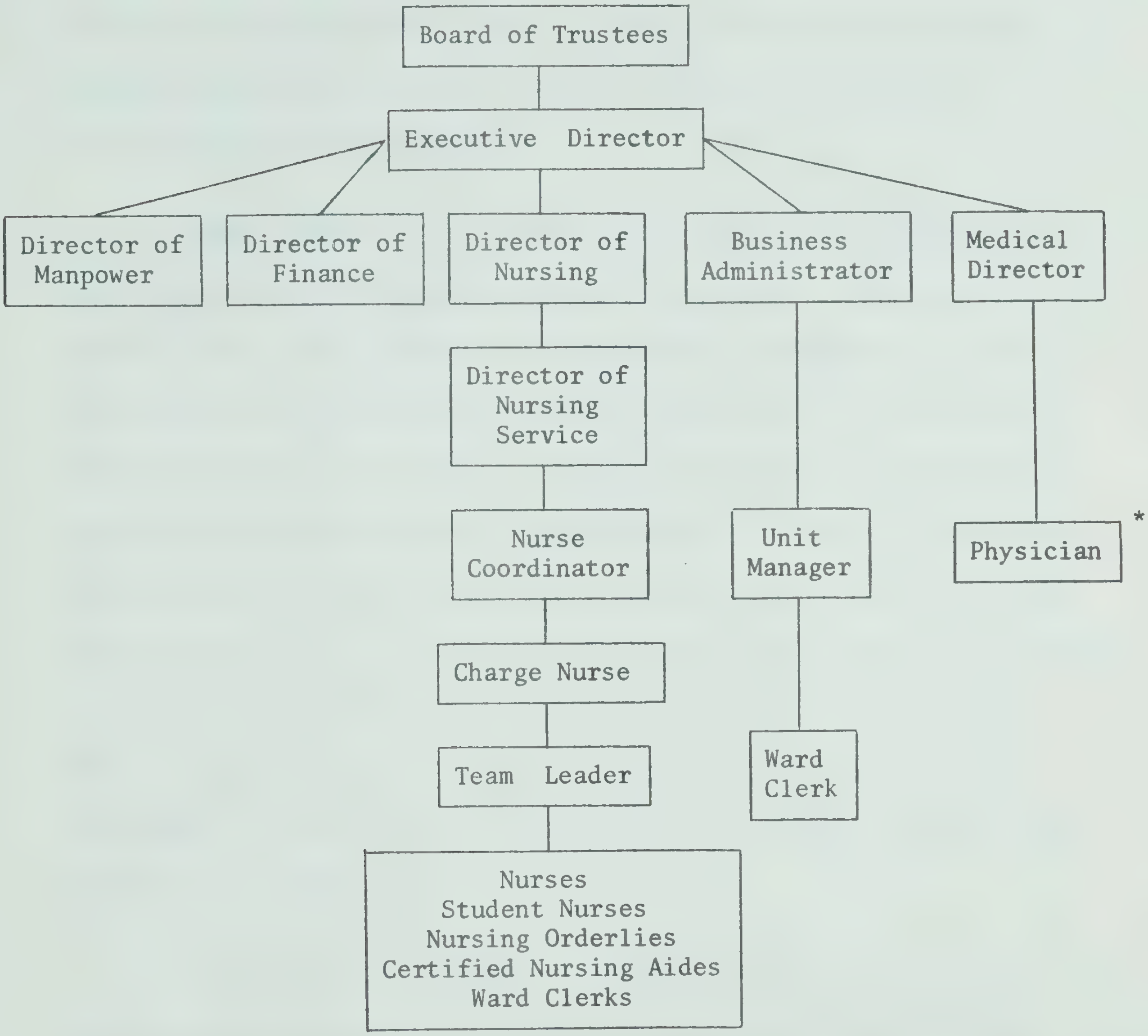
[13] Memo from Coordinator of Management Centers to members of the Administrative Committee, "Pilot Project -- Unit Management," University of Alberta Hospital, May 1, 1969, p. 2.

## CHART II

### Proposed Organization Chart
### UNIT MANAGEMENT SYSTEM PROJECT



* It must be noted that this Chart depicts the hospital administrative organization. Although the Board of Trustees, the physicians and the executive director comprise three centers of authority, in regard to administrative decisions and general management, the physicians are part of the hospital administrative authority. They have the same relationship in the hierarchical line of command as do others. Physicians are part of their own professional system as well as being members of the hospital organization. The physicians, through their own medical staff association and medical committees, have direct advisory contact to the Board of Trustees in matters related to medical care.

non-nursing activities, thus enabling the Charge Nurse to develop in a role of nursing care management. She said the link between non-nursing and administrative functions with nursing functions at the nursing station level could coordinate services and information ensuring improved total management.[14]

Other members of the Administrative Committee said roles of ward clerks and Unit Managers seemed to be similar. The Medical Director said a Unit Manager position could be occupied by a person with clerical and receptionist ability, who would relieve nurses of clerical duties.[15] He said the concept of a position occupied by a person with formal educational preparation in managerial techniques, coordinating all services related to patient care within a specified area was not realistic in view of the costs. The Director of Finance said it seemed logical that appointments of ward clerks and Unit Managers should reduce the number of nurses.[16] This statement was challenged by the Director of Nursing who said present nursing staff patterns were inadequate.

The Director of Manpower said it was necessary to examine services and activities required to meet patients' needs and then allocate categories of staff according to patients' needs. He commented that employment of Unit Managers and clerks could offer benefits

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[14] Interview with the Director of Nursing, May 28, 1970.

[15] Interview with the Medical Director, January 29, 1970.

[16] Interview with the Director of Finance, February 3, 1970.

to patients and to the hospital in terms of efficiency, including reduced costs. He also said that unless nurses were prepared to look at and measure what they could be freed from in a Unit Management System, and for what, the system might be costly for the hospital.[17]

The Business Administrator said many nurses did not believe that non-nursing functions should be delegated to auxiliary personnel such as Unit Managers. He said nurses believed these functions were part of the total patient care concept and the responsibility of registered nurses. He added that patients and staff wanted a nurse as the manager of the ward, and lay personnel would not be, and indeed, possibly should not be, accepted on wards to perform functions that were traditionally nursing functions.[18]

Each member of the Administrative Committee said that the potential for improved care at reduced costs persuaded them that there should be advantages in the project. At the same time, they expressed concern that such terms might bring opposition from many nurses. One suggestion was that Unit Managers should be under the control of Charge Nurses. However, the Director of Nursing supported the principle of the proposed system. She said that it would be "professional suicide"[19] for nurses to continue to assume responsibility for non-nursing functions. She added that, providing

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[17] Interview with the Director of Manpower, February 11, 1970.

[18] Statement by Business Administrator at Meeting, May 25, 1970.

[19] Interview with Director of Nursing, May 28, 1970.

there were modifications in the organizational structure, the benefits of the Unit Management System should be improved professional nursing care. She also said that she did not believe that benefits would necessarily be found in the reduction of costs of nursing staff.[20]

## Second Proposal by the Project Director

In June 1969, the Project Director and Nurse Coordinator visited a number of hospitals in Canada and the United States seeking information about Unit Management Systems. They were enthusiastic about a Nursing Unit Management Project at Evanston, Illinois, where there was a "triad system" of organization.[21] Shortly after the tour, the Project Director presented another proposal for the Unit Management System project to members of the Administrative Committee. He recommended the position of a Unit Manager should be at the same hierarchical

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[20] Interview with Director of Nursing, May 25, 1970.

[21] Each service in this institution has a triumvirate -- physician nurse, administrator -- responsible to their respective principals for the delivery of patient care in the service. These three individuals, with delegation, identify and correct problems in their areas. A report of the Nursing Unit Management Project at the Evanston Hospital explains that the hospital system simplifies nursing unit operation by such actions as policy interpretation, policy exception and the conduct in interdisciplinary and departmental relationships.

The Evanston Hospital carried out a project in which a task identification was performed so that nursing and non-nursing tasks could be analyzed with the purpose of determining functions and appropriate assignments of responsibility in terms of nursing and non-nursing functions. As a result of the project, a Unit Administrator was appointed for the purpose of performing all duties said to be inappropriate to nursing personnel. Responsible to the Triad Administrator, the Unit Administrator supervised the ward secretary, relieved nursing of administrative duties and achieved improved unit relations with supporting departments.

Report of Nursing Unit Management Project, Evanston Hospital, Illinois, U.S.A., April, 1965.

level as a Charge Nurse and responsible for non-nursing and managerial functions on two nursing stations.

Recommending a method of cooperation known as the Triad System for the project, he wrote:

> Under the Triad System, patient care areas are divided by clinical specialty. Each area has a nursing supervisor, a physician appointed as a representative of the specialty, and an administrator. Together as peers, the triad members plan for and manage delivery of total patient care in their particular clinical areas. The nursing supervisor is responsible to the Director of Nursing Service, the physician to the Chief of his department and the administrator to the Business Administrator. The current organization for the project permits the establishment of a Triad. The medical liaison person, who has been appointed, would become the medical staff representative and the Coordinator of Management Centers would become the administrative representative on this Triad. This group would develop the total management within their areas, each contributing their own particular expertise. The Triad should isolate and solve problems at the middle management level. This system involves those people who are managing the department in decisions affecting their areas.[22]

The Project Director added that the administrator in this structure should be known as a Patient Care Administrator. He wrote:

> . . . the Patient Care Administrator is responsible for providing the non-professional patient care to the patient. He does this by direct actions and by coordinating the facilities of the various service departments. Like his subordinate assistants, the Unit Managers, he is the patient's agent within the hospital. The provision of patient care by administration is neglected in this hospital at present and only takes the form of answering specific complaints. It is suggested that these complaints can be abated by understanding the needs of the patient at an early stage and that the lot of the patient can be considerably

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[22] Unit Management proposal to members of the Administrative Committee by Coordinator of Management Centers, University of Alberta Hospital, July 25, 1969, p. 3.

> improved in our hospital by developing this concept of total patient care.[23]

Originally, the Unit Management system had seemed simple. A Unit Manager would perform general managerial and non-nursing functions for a designated patient care area. The complex organizational picture involving two sets of "triads" (see Chart III) was viewed by some members of the Administrative Committee as a repetition of the traditional hospital organization structure in which there are three power centers. Two respondents expressed concern about the consequences of the accommodation of group interests and the danger that different interests could bring about conflict. The creation of another position for a Patient Care Administrator and the entailed costs were issues of concern. However, the Director of Nursing said the Triad System in which general managerial responsibilities and non-nursing activities would be delegated to personnel other than members of the Department of Nursing, would enable nurses to give more professional nursing care to patients. In addition, the Project Director said he would enact the role of the Patient Care Administrator, thus eliminating a cost factor.

In interviews, when Divisional Directors were asked for whom, and for what, the proposed system was functional, each respondent emphasized that it seemed to be a means of attaining efficiency in the delivery of patient care by improved utilization of nursing staff.

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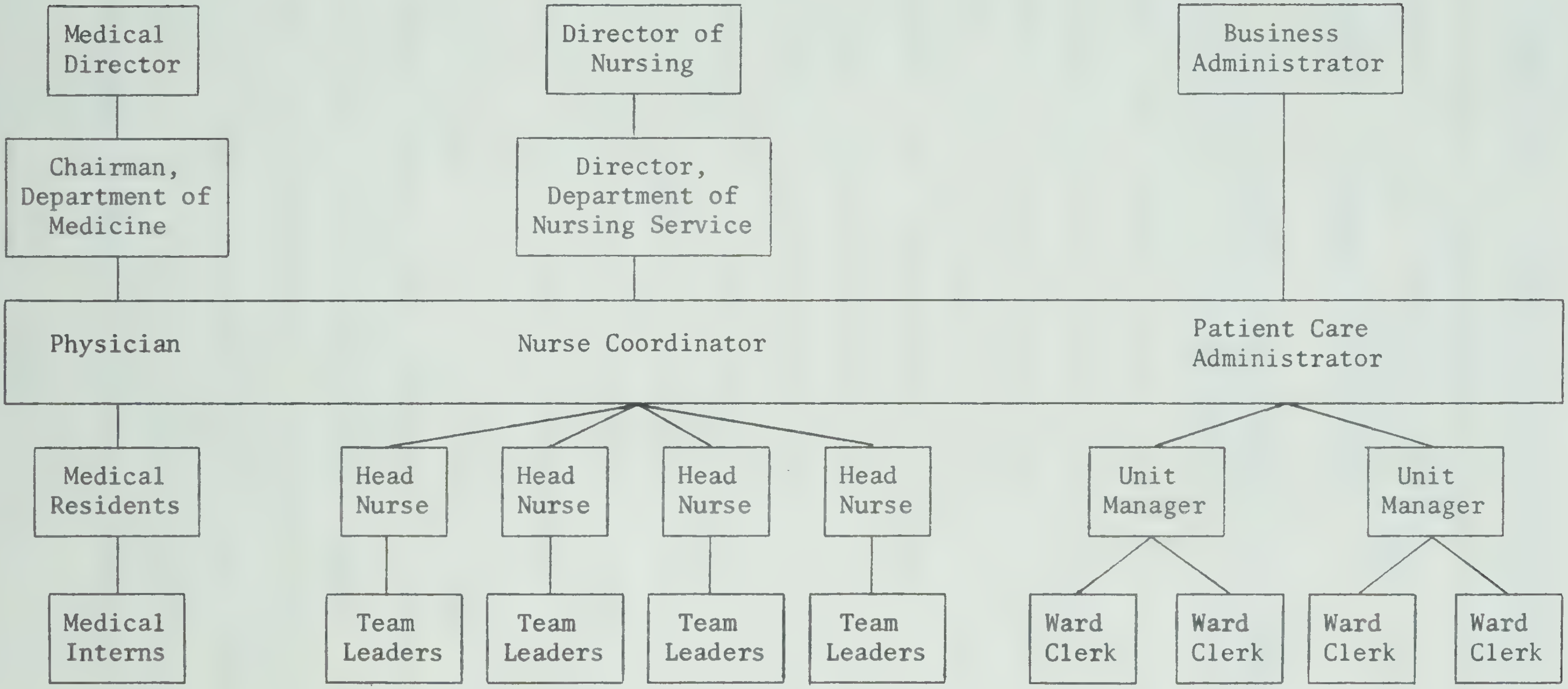
[23] Ibid., p. 2.

## CHART III

### Organization Chart
### UNIT MANAGEMENT SYSTEM PROJECT
### TRIAD SYSTEM



Each member accepted that a reallocation of non-nursing and administrative functions should lead to improved utilization of nurses. They also said reduction in costs of nursing services should not be at the cost of reducing the standard of nursing care.

Thus, in the opinion of some respondents, the nursing profession's efforts to direct "educated nurses" back to the bedside would not contribute toward efficiency because some functions being conducted by registered nurses could be performed by less trained and less expensive personnel. In contrast to this view, the Director of Nursing expressed concern that less trained personnel might practice beyond their competencies. She emphasized that a Unit Management system should be a system to provide registered nurses with the opportunity to practice professional nursing care in effective comprehensive nursing care and that it would not necessarily reduce costs in dollars. The Executive Director emphasized that, unless the project indicated that the same standard of nursing care would be provided at the same or reduced costs, the Unit Management System would not survive.

Information provided by interviews with members of the Administrative Committee suggested that there was not a consensus of opinion that new categories of workers might reduce the numbers of nurses, or in other words, decrease expenditure. The concept that efficiency should increase as costs decrease and that the same standard of patient care should be produced at a lower cost was described by some respondents as vague because "sameness" could not be established.[24]

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[24] Etzioni suggests that although organizations under pressure to be rational, attempt to measure efficiency and to achieve (...contd)

On August 18, 1969, the Administrative Committee members agreed that the Triad structure for the Unit Management System was acceptable. The Director of Nursing selected four wards for the project. The Nursing Coordinator, in addition to liaising with the Project Director and implementing changes in nursing, would continue to occupy the supervisory position in which she was responsible to the Director of Nursing Service (see Chart IV).

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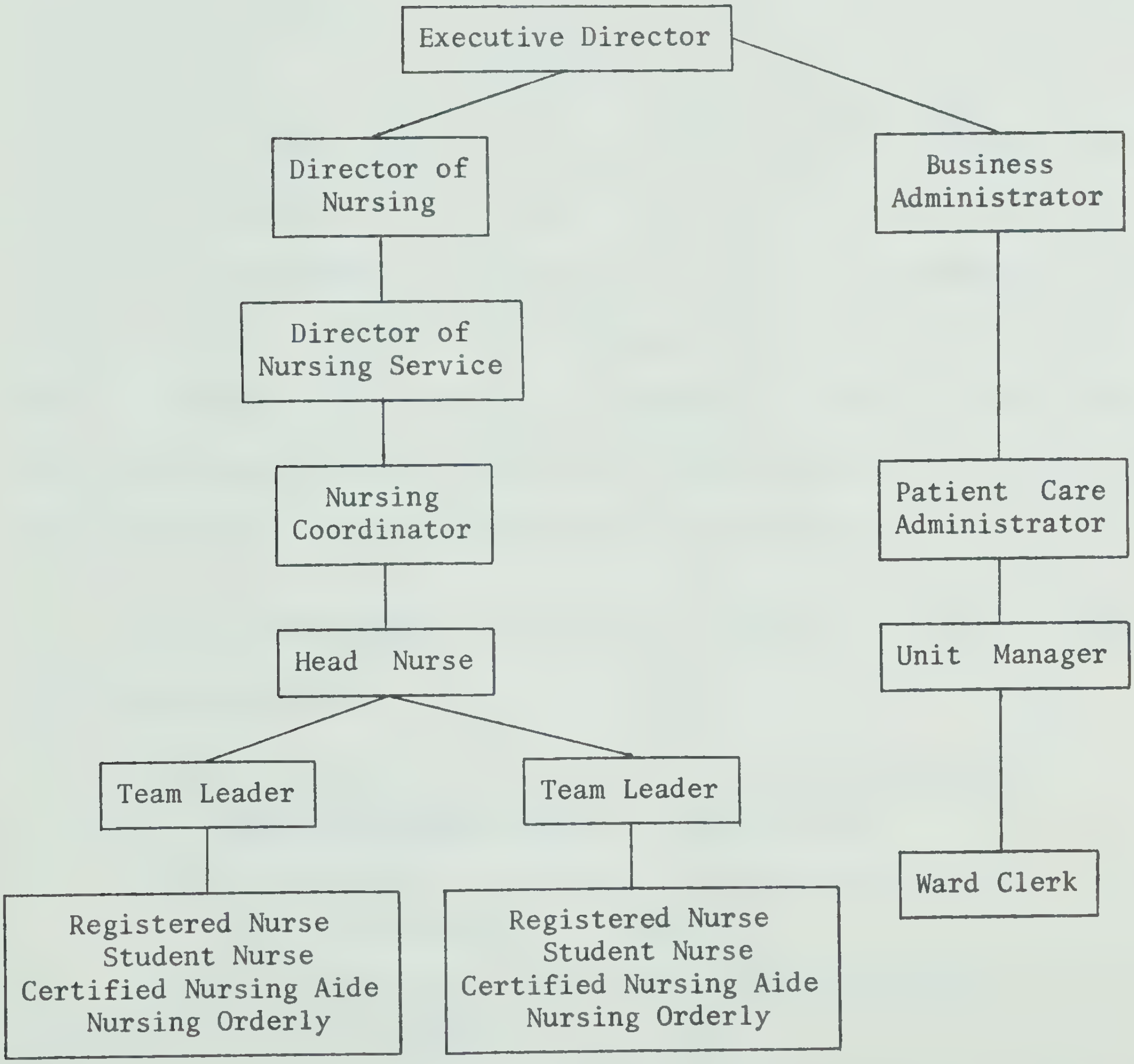
Footnote #24, continued:
success, their attribution of too much importance to some indicators of success and not enough to others may lead to an undermining of the efficiency and effectiveness sought. He also suggests that statements about effectiveness in an organization, such as a hospital, whose output is not material are difficult to validate. He concludes that efficiency and effectiveness do not always go hand in hand and that overconcern with efficiency may limit organizational activities when effectiveness may require varieties of activities. Amitai Etzioni, Modern Organizations (New Jersey: Prentice-Hall, Inc., 1964), pp. 8-9.

CHART IV

Organization Chart
NURSING SERVICE UNIT MANAGEMENT



# CHAPTER IV

# IMPLEMENTATION OF THE UNIT MANAGEMENT SYSTEM

## Introduction

This chapter covers a period of investigation conducted from September 1969 until October 1970, and combines the presentation and analysis of data about the implementation of a Unit Management System in four wards at the University of Alberta Hospital. An attempt is made to interpret the processes that governed relations between individuals and groups during the period of implementation and to demonstrate the complementary nature of the theories of Weber and Strauss.

The implementation process will be analyzed by focusing upon the following dynamics:

(1) the bureaucratic processes of defining objectives and implementing means to achieve them;

(2) the informal processes of negotiation related to bureaucratic ends and means;

(3) the interaction within and between each of the above processes.

For purposes of description, the chapter is divided into three successive but overlapping and interpenetrating phases -- a planning phase, the phase of the implementation of Unit Manager positions, and the phase when the roles of Team Leaders and Head Nurses changed. Although the phases overlapped in the period of time, each phase represents

a period in the overall history of the implementation process. Therefore, they are introduced in chronological order so that the main issues and problems that arose about the events defining each phase are discussed to their logical conclusion. Because of this, for example, the discussion about the planning process in the first phase, actually concluded after the events in the second phase had commenced. While this will create a certain amount of difficulty for the reader, it is expected to be less than if the complex of issues and problems were intermingled.

## The Planning Process: Phase I

The unilateral decision to implement a Unit Management System in four wards was in accordance with the classic Weberian concept of a bureaucratic organization in which the administrative structure was instrumental in initiating the change. The nursing staff at the ward level were not involved in the decision to establish a new system. The majority of the nurses and physicians heard about the proposed change by memoranda and at meetings after the Project Director had been delegated to institute the change.

Although the proposed change was intended to free nurses to practice nursing, it generated much conflict. There seemed to be a lack of clarity about what nurses wished to be freed from -- or to be freed for -- and the majority of the nurses and physicians became divided over the basic question of who should perform which specific procedures. Should non-nursing tasks be delegated to Unit Managers, or were these tasks part of the total patient care concept, and the

responsibility of professional nurses? According to one physician, the more the nursing staff could do for patients, the easier it is to coordinate the services received by patients. He said that the concept of Unit Management with ". . . its direct extension of management to the patient care unit. . . ."[1] was an artificial method devised to disturb the stability of the wards where nurses directed the work of nursing staff, as well as controlled the work of personnel from other departments who performed specific patient services. He stated:

> The wards have been the only place where Administration has not built an office. Now, through Unit Managers, Administration is invading the last stronghold of physicians, nurses and patients.[2]

The existence and importance of anxieties about the introduction of changes in the four wards was recognized by the Project Director but he felt that if the change was carefully planned, the timing and direction appropriate, and administrative and financial support provided, the change could be introduced successfully. The Nurse Coordinator appointed to liaise with the Project Director emphasized that the proposed changes would be introduced gradually.

The Project Director and the Nurse Coordinator briefed physicians, nursing supervisors and department heads about the Unit Management System and its objectives:

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[1] Norman Brady, et al., "The Unit Manager," Hospital Management, 101:30 (June 1966), p. 32.

[2] Interview with a physician, March 8, 1970.

(1) removal of administrative and non-nursing management tasks from nurses;

(2) extension of Business Administration to patient care areas to provide administrative control and services;

(3) provision of the same or an improved standard of patient care at the same or reduced costs.

The structural modifications to be effected were described and organizational charts were used to demonstrate the new organization structure consisting of two divisions of labor (see Chart III). The procedural changes were to include non-nursing and general managerial functions being transferred from the Department of Nursing Service to the Division of Business Administration. A key part of the new structure was the establishment of Unit Managers at the same hierarchical level as Head Nurses but responsible through a chain of command to the Business Administrator for day-to-day coordination of non-nursing services and general managerial activities at the ward level. The traditional nursing structure would remain unchanged. Team Leaders, Head Nurses, and the Nurse Coordinator would be responsible to the Director of Nursing Services.

Prior to the employment of Unit Managers, the Project Director and Nurse Coordinator made a careful study of the functions performed by the professional nurses related to handling equipment, supplies, problems dealing with admitting and discharging patients, and communication with departments such as the laboratories. As a consequence of their examination, they established and put into operation new systems for the Ward Clerks to handle many clerical routines. They trained Ward Clerks to perform activities generally performed by

professional nurses. In a further effort to achieve the objective of better utilization of nursing staff, the Nurse Coordinator developed records, worksheets and schedules, so that there was a more effective system of communication on each ward. At this point, the Project Director and Nurse Coordinator then provided lectures about the Unit Management System and the changes in the roles of Team Leaders and Head Nurses to staff in the four wards.

## Conflict of Interests

Discussions held between the physicians and nurses led to the questioning of the feasibility of a system in which a Unit Manager was another kind of worker in the wards. When they understood that a Head Nurse and a Unit Manager would have equivalent status, nurses and physicians were primarily concerned with problems they predicted would arise when there were two chiefs in one ward. Physicians and the majority of the nurses felt that a nurse should control the total management of the ward. The Project Director responded to this challenge. He stated that nurses were not trained to be general managers. Nurses could be more effectively utilized if Unit Managers would manage the hotel functions of the wards.

Conflict over the right of a Unit Manager to share with a Head Nurse the management of a ward, generated a tension that was disseminated through the hospital to other nurses and physicians. They, too, questioned the criteria by which "non-nursing tasks" might be separated from "nursing tasks." They also suggested that the employment of additional nurses, able to accept responsibility for diverse

functions, would be more efficient and effective than the employment of Unit Managers without training in either hospital management or nursing. The nurses and physicians believed in the traditional role behavior of a Head Nurse. This was considered to be legitimate, in part, because physicians, nurses, and patients supported and approved Head Nurses when they functioned in traditional ways.

The majority of nurses and physicians acknowledged that Head Nurses -- busy with desk work and obtaining supplies and equipment -- were often unable to give direct nursing care or supervise the provision of such care. Many nurses and physicians also said that Nursing Supervisors were seldom involved in patient care because they were occupied with functions related to other services. Nevertheless, the majority emphasized that the person responsible for the management of a ward should be a nurse whose knowledge of medical care, nursing care, and patients' needs provided her with the requisite background.

The four Head Nurses in the wards where the system was to be introduced were apprehensive that the transfer of administrative responsibilities, which in the traditional pattern were a means to maintain relationships with physicians and other members, would lessen their control of the total situation on the wards. They also felt that in the managerial role a nurse would be more knowledgeable about the needs of patients and staff and therefore would have influence that Unit Managers would lack. On the other hand, the Nurse Coordinator felt that nurses should not continue to be involved with non-nursing tasks and the "hotel" functions.

Much of the interchange that went on was a result of the Unit Management System becoming a threat to the control and also the career prospects that nurses had hitherto enjoyed. Concern was expressed when nurses asked by what route they might obtain promotion in the system. They said the Unit Management System might provide nurses with opportunities to practice nursing but it might also introduce limitations upon careers and career advancement as this had traditionally occurred through the administrative hierarchy.

To a degree, the concern was also related to the fact that nurses perceived "non-nursing tasks" as part of total patient care, and therefore within the responsibility of professional nurses. For example, nurses at first rejected the plans for clerks, supervised by Unit Managers, to transcribe physicians' orders, because they believed such activities to be part of the nursing function. Similarly, the Nurse Coordinator's invitation that the Head Nurses and professional nurses suggest other functions to be performed by Unit Managers and ward clerks, did not induce nurses to offer to relinquish many tasks.

A few nurses did indicate a willingness to share administrative responsibilities with non-nursing personnel. They were confident Unit Managers could perform many functions presently carried out by nurses. They thought that the Unit Management System could enable nurses to provide more direct nursing care to patients, have more time to assess patients' needs, make nursing decisions and initiate action to resolve nursing problems. However, it seems that the majority felt that the Unit Management System should be only a means to

relieve nurses of minor tasks that they did not wish to perform and should not interfere with the traditional managerial role of a nurse in charge of a ward.

## Grounds for Negotiation

The discussion up to this point indicates that there was little impact of professional nurses upon the "negotiated order." It was clear that they wished to control conditions of their work as much as possible because they invoked ideological and judgemental bases for not changing traditional practices. The potential for negotiative processes was evident when a Head Nurse had this to say:

> I am told that my role will not be the same as the role of a nurse in charge of a ward in other areas of the hospital, however, I will still be in the same position. Doctors will expect me to behave like a nurse in charge of a ward. So will personnel in other departments.[3]

The nurses felt that the proposed changes in the role of a nurse in charge of a ward constituted, initially at least, a threat to the relationships of physicians and the nurse in charge. Furthermore, they said that it was inappropriate for a nurse in charge to become involved with nursing care activities generally performed by graduate nurses, certified nursing aides, nursing orderlies and student nurses. They did, however, accept the administrative decision for change to be implemented.

Notwithstanding the unwillingness of the nurses, the Nurse

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[3] Interview with a Head Nurse, February 5, 1969.

Coordinator listed functions that could be transferred from professional nurses to Unit Managers and Ward Clerks. She directed the Team Leaders and Head Nurses to assist to develop job descriptions for Team Leaders, Head Nurses and the Nurse Coordinator. With her guidance and assistance, job descriptions were produced. The precise way in which details of the changes were spelt out in these job descriptions prepared the nursing staff within the four wards to become familiarized with the proposed alterations in their roles.

The job descriptions transferred many non-nursing activities of Head Nurses to Unit Managers. The Unit Managers would be responsible for ordering, obtaining and storing general and special supplies; ensuring cleanliness in the patient areas by acting as a liaison between the ward and the Housekeeping Department; checking and requesting repairs of equipment and renovations; orienting staff and patients to the Unit Management System; solving patients' problems about hotel services, as for example, lost valuables and clothing; and, supervising clerks and clerical activities.

The Nurse Coordinator was described as the Unit Director of Nursing who would work with the Patient Care Administrator to attain the objectives of the Unit Management System program. She would be the administrative member of the nursing staff, responsible and accountable for standards of nursing care and control of nursing personnel in the unit. The Head Nurse, responsible for the management of nursing care and nursing personnel within a ward would be a nurse specialist, involved in planning nursing care, teaching both patients and staff.

The Team Leader, supervised by the Head Nurse, and responsible for planning and managing the nursing care of a given number of patients, would perform many nursing routines considered to be tasks of a nurse-in-charge in the traditional system.

At this point in time, the Project Director selected two Unit Managers. One Unit Manager was a young man with university preparation in an Arts program and the other was a woman, who had been employed for seventeen years in the Business Office at the Hospital. The process of the selection illustrates the way in which the Project Director and Nurse Coordinator functioned. The Nurse Coordinator took an active role in interviewing applicants. Both the Project Director and Nurse Coordinator were aware of the inherent problems facing Head Nurses and Unit Managers and they interviewed applicants for the positions with care. In making decisions about plans for training Unit Managers, the Project Director consulted the Nurse Coordinator, but the decisions about the Unit Management System were his. Similarly, the Nurse Coordinator, in planning for the changes in roles of professional nurses, often consulted the Project Director to ensure that plans for nursing were consistent with the plans for the Unit Management System.

The purpose of workshops directed by the Nurse Coordinator was to enable the nursing staff to learn about the changing role of a Team Leader, and a Head Nurse, as well as to be provided with information about the duties assigned to Unit Managers and Ward Clerks. The two Unit Managers received instruction about the organization of the hospital, departments, services, and routines through which Unit Managers

would obtain services. They learned that the nursing department was responsible for interdepartmental coordination of most functions but that in the Unit Management System, Unit Managers would be responsible for directing and coordinating "hotel functions."

After two weeks of general orientation, the Unit Managers spent one week working as Ward Clerks and then they were assigned the task of ordering, obtaining and storing supplies. They were advised and assisted by the Head Nurses. It was understood that at the end of three months the Unit Managers would assume responsibility for the "hotel functions" of the wards. They would also relieve the Head Nurses and Nurse Coordinator of administrative routines related to the general management of the four wards.

At the Medical-Nursing Meetings, on each ward, the Project Director and Nurse Coordinator described the proposed changes to the medical staff and asked the physicians for their cooperation. The concept of the Triad System (see Chapter III, pp. 39-40) was presented and a staff physician agreed to work with the Project Director and the Nurse Coordinator to coordinate nursing, medical and administrative interests in the unit.

The major change planned by the Project Director and Nurse Coordinator was to be a decentralization of control of the wards. They believed that decision-making, responsibility, authority and accountability should be at the ward level. They focused upon nursing in particular. Their goal was a structure that would provide a setting where professional nurses would function as professionals with freedom

to make independent judgements and decisions about nursing care. The proposed change for a decentralized structure in the four wards generated considerable interest not only among the nursing staff in the four wards but among other nurses in the hospital.

At this point, it can be seen that even though the original decision to introduce Unit Managers was in the classic Weberian tradition,the actual planning for the implementation of the Unit Manager positions deviated from this tradition insofar as consultations of subordinates was freely sought and carefully considered. Bureaucratic procedures were nevertheless used to deal with the details of transferring functions and tasks from Head Nurses to Unit Managers and Ward Clerks. For example, although there had been extensive discussions with the Head Nurses and Team Leaders directly involved, Head Nurses were directed to transfer specific activities to Unit Managers and to Ward Clerks, whether or not they had agreed with the concept in their informal discussions. Responsibility for non-nursing functions such as ordering supplies, arranging for renovations, obtaining equipment, supervising Ward Clerks and acting as liaison for the ward with related services, now would be located with Unit Managers. In this phase there was no negotiative activity, although the grounds for negotiation were established.

While it might be anticipated, in terms of the discussion in Chapter II, pp. 17-21, that the bureaucratic decisions would have generated negotiations, it does not seem unreasonable to expect that the bureaucratic procedures would have precluded or minimized such

negotiations in the next two phases of the implementation process. Such was not to be the case.

### The Implementation of Unit Managers: Phase II

The most striking difference in behavior between nurses and Unit Managers in the first phase and the second phase of the implementation process was the bargaining in the latter and its absence in the former. The difference was related to attitudes and values that could not be recognized by the majority of the nurses in the context of abstract discussions during the planning phase. Thus, the value the nursing staff placed on the traditional structure as well as the inherent difficulty in distinguishing between nursing and non-nursing functions, generated opposition to the rules governing the activities of the Unit Managers.

The procedures, designed to achieve the objectives of the Unit Management System in the four wards, had unanticipated consequences for these objectives. Tension developed in spite of the careful administrative preparation and planning that occurred prior to the actual establishment of the Unit Manager positions, and the agreements made by the nursing staff with respect to activities of the Unit Managers and the Head Nurses. It resulted from disagreements between Unit Managers and nurses about the division of responsibility. The nursing staff understood that Unit Managers and Clerks would relieve nurses of specific non-nursing activities. It was not clear to them that Unit Managers would take over some of what they perceived to be the authority of a Head Nurse. Conflict arose because the four Head Nurses

continued to act within definitions of their traditional roles. In addition, personnel in other departments also continued to get work done according to the familiar routines in which they related to Head Nurses. When the Unit Managers attempted to enforce the "rules" about their assigned activities in the four wards, the nurses frequently referred to the "rules" in other wards in countering these demands.

An illustration of the kind of problem that caused disagreements leading to negotiations was shown during one interval when a Head Nurse was observed handling four separate telephone enquiries related to housekeeping, transportation of patients to the radiology department, information about staff rotations and instructions about the discharge of a patient. Between telephone conversations she transcribed physicians' orders to cards, directed a Ward Clerk to take specimens to the laboratory, gave information to one physician about reactions of a patient to medication and, discussed with another physician the post-operative behavior of patients. In this case, the Head Nurse was still recognized as a coordinator, manager of patient care and the person in charge of the ward. She ignored the rules that the Ward Clerk, supervised by the Unit Manager, would transcribe physicians' orders, and answer the telephone and, that the Unit Manager would coordinate both transportation of patients and messenger services.

## Unit Managers and Negotiated Order

Initially, bargaining between the Head Nurses and Unit Managers was implicit; it took the form of the Head Nurses retaining a control on activities that had been officially transferred to Unit Managers. In

order to perform their duties, Unit Managers required information about equipment, supplies, routines and procedures. What information the majority of the nurses were prepared to supply or activities they relinquished, depended upon their judgement. They were influenced by beliefs about the appropriateness of Unit Managers to assume responsibility for activities they still perceived to be part of nursing, or the responsibility of the Head Nurse. The problems related to the transcription of physicians' orders by Ward Clerks, supervised by Unit Managers, and also the criticism that Unit Managers were ignorant about hospital routines and procedures, were a result of the failure of Head Nurses to inform Unit Managers how to perform tasks delegated to them, and to carry out their duties. Nurses, because they were nurses, exerted influence and authority that Unit Managers could not.

Once it was realized that the Unit Managers and nurses were engaged in games of give-and-take, in attempts to control conditions of their work, the Project Director and Nurse Coordinator began to supervise their activities closely. As a result, further negotiations between Unit Managers and Head Nurses were frequently avoided because the Project Director and Nurse Coordinator together made formal decisions about what activities would or would not be performed by Head Nurses and Unit Managers. Furthermore, formal decisions were made to discuss and state the issues that arose.

These bureaucratic decisions were also part of a bargaining process. For example, if a Head Nurse continued to perform activities assigned to a Unit Manager, the Nurse Coordinator requested the Head

Nurse to demonstrate that she was carrying out her specific responsibilities in relation to patient care, supervision of staff, and teaching. This approach influenced the Head Nurses in deciding to relinquish activities to Unit Managers.

The adroitness with which the Nurse Coordinator guided both the Head Nurses and nursing staff to give away tasks to the Ward Clerks and Unit Managers helped in this transition period. When the Nurse Coordinator noticed a Head Nurse writing a requisition, or struggling with equipment, she would make a comment such as: "The Unit Manager can take care of that. May I join you at the team conference?" Moreover, the Project Director and Nurse Coordinator arranged meetings between physicians, nurses and Unit Managers to pursue discussions about the purposes of the Unit Management System program and the interdependency between Unit Managers and Head Nurses in the provision of patient care.

The majority of the nurses and physicians continued to reject the idea that Unit Managers could be assigned responsibility for functions that Head Nurses traditionally performed; they said that additional nurses were required instead of Unit Managers. The Unit Managers, supported by the Nurse Coordinator and the Project Director offered to relieve nurses of additional non-nursing tasks so that nurses would have more time for direct patient care. A significant sociological feature of these regular meetings was their provision for problem solving and discussions and the fact that they provided an outlet for anxieties as well as being an educational process.

In interviews, Head Nurses and Unit Managers said that the structured meetings helped in that the recognition each person received from each other supported them both individually and in the group during the adaptation to the organizational change. Furthermore, because the Project Director and the Nurse Coordinator worked together as a team, consulting each other about the administration of general managerial functions and patient care management,the Unit Managers and Head Nurses commenced to understand how the Head Nurse-Unit Manager role should develop.

While it is true that agreement about the main objectives of the Unit Management System, particularly in regard to nursing, contributed to a better relationship between the Unit Managers and Head Nurses, the activities of the Nurse Coordinator and the Project Director were of significance. The Nurse Coordinator insisted that both the Head Nurses and the nursing staff should comply with the procedural changes. For example, the transcription of physicians' orders by Ward Clerks was not willingly transferred by nurses. The situation is shown in the following comment by a Head Nurse:

> What a system! Three people are now involved in tasks formerly performed by one nurse. The Unit Manager supervises the clerk who transcribes the orders. I check the transcriptions. Now what do I do? The Unit Manager is the clerk's boss. Do I go to the Unit Manager and tell him that the transcripts are incorrect and does he then tell the clerk to rectify her mistakes or do I have the authority to tell the clerk that she has made a mistake?[4]

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[4] Interview with a Head Nurse, April 3, 1970.

In spite of their unwillingness to relinquish this activity, the nurses eventually complied with the Nurse Coordinator's directions that Ward Clerks would transcribe the physicians' orders to requisitions and the Kardex. The Nurse Coordinator found it was necessary to remind nurses that they were responsible for checking the transcriptions. The Project Director continued to explain that the Ward Clerks performed only the mechanical activities, and that nurses were responsible for the accuracy of the orders. Nurses stated they preferred to work on evening and night shifts when Ward Clerks and Unit Managers were not on duty because nurses could complete routines initiated by physicians' orders in one operation. However, during the day shift, nurses complied with the rules about clerical routines to be assigned to Ward Clerks. Gradually, nurses relied on the Ward Clerks. One nurse said:

> It is so nice to drop the patient's chart on the Ward Clerk's desk and to know that when you return the requisitions have been completed.[5]

The clerical system was being smoothly implemented. The Unit Managers had established an efficient method of ordering, storing and checking supplies, and equipment when another complexity arose. The Unit Managers and the Ward Clerks began to say that they had an unreasonable workload. In turn, the nurses who now felt that it was their right to leave clerical routines to Ward Clerks, and responsibility for activities related to supplies and equipment to the Unit

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[4] Interview with a Graduate Nurse, May 15, 1970.

Managers, began to say that nurses should not be expected to do work which, according to the rules, was not their responsibility. The issue was whether Unit Managers were indeed responsible for their assigned duties or whether their responsibility was only for the day shift, five days each seven-day week.

The Project Director and the Nurse Coordinator explained that nurses must continue to perform some non-nursing tasks because cost factors prevented employment of additional Unit Managers for day shifts as well as afternoon and weekend shifts. Eventually there was agreement, more tacit than explicit, that nurses would continue to perform non-nursing functions when Unit Managers and Ward Clerks were absent. Nurses emphasized that additional Unit Managers should be employed if nurses were to perform only in nursing roles. Nurses left little doubt that they would continually review the issue. One Team Leader said that the nursing team had been reduced by a Certified Nursing Aide in order that a Unit Manager could be employed. It was her opinion that although the Unit Management System might be a worthwhile innovation, it should not function at the expense of a reduction of the numbers of nurses essential to provide nursing care, nor should Unit Managers transfer their responsibilities back to nurses on afternoon and night shifts.

The issue about a reduction of nursing staff to pay for Unit Managers generated negotiative activity. It will be recalled that the Director of Nursing believed that the nursing staff should be supplemented by Unit Managers, thus enabling the nursing staff to redirect

their time to give more nursing care. The conflict between nursing objectives and administrative objectives became explicit when the Executive Director stated that the Unit Management System could only be implemented if the same standard of patient care was provided at the same or less costs. Disagreements that arose as a result of these conflicting views produced tension that was further increased when the Director of Finance asked why the number of existing positions for nurses would not be reduced with the employment of Unit Managers. He said it was difficult to understand why additional staff was required for a rearrangement of functions. The Project Director also reflected this opinion in his statement about an objective of the Unit Management System. He said:

> Its [the Unit Management System] inception must have a cost basis and this lies in the improvement of patient care at a minimal cost, or the reduction of cost by eliminating nursing positions without any change in patient care standards.[6]

Confronted with this issue the nurses bargained for Unit Managers in addition to the nursing staff if nurses were to continue to provide even minimally acceptable standards of professional care. The Nurse Coordinator and the Director of Nursing also argued against the reduction of nursing staff. In order to attain a nursing objective of separating non-nursing functions from nursing functions for nurses, however, they were forced to agree that the budget for Unit Managers' salaries

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[6] Memo from Coordinator of Management Centers to members of the Administrative Committee, "Pilot Project -- Unit Management," University of Alberta Hospital, May 1, 1969, p. 2.

would be provided by the Department of Nursing Service. In short, the bureaucratic decision about the source of the salaries of Unit Managers was not influenced by the negotiative activities of the nurses.

A second issue that illustrated negotiative activity concerned the attempts of the Unit Managers to establish roles for themselves. The attempt of the Head Nurses to defend their traditional roles and to stabilize their positions vis-à-vis the Unit Managers led to disagreements between the Head Nurses and the Unit Managers and these disagreements led to informal bargaining. As it has been already noted, the bargaining technique used by the Head Nurses was to retain a control of information required by the Unit Managers if they were to function effectively. The strategy of the Unit Managers appeared to be designed to provide a middle course between the concept of bringing Business Administration to the wards and the concept that Unit Managers served nurses. In the working situation, Unit Managers often were willing to perform tasks, errands and chores for the nurses. They frequently submitted to the traditional nursing practices because it was convenient for the nursing staff or because they felt an exigency about a patient had arisen so that it was untimely to be concerned about who was assigned to which task.

However, the willingness of the Unit Managers to accept values of nurses about traditional nursing functions changed an objective of the Unit Management System. This was demonstrated about six months after the commencement of the program when a visitor was informed by a Unit Manager that Unit Managers "assisted the nursing staff."[7]

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[7] Interview with a visiting graduate nurse, August 15, 1970.

A bureaucratic decision about the role of a Unit Manager as a coordinator of hotel functions and a representative of administration at the ward level was altered as a result of agreements between nurses and Unit Managers that were arrived at through informal negotiations. Unit Managers established roles for themselves and were accepted by the nursing staff only when they tacitly agreed that Unit Managers assisted the nurses.

A third issue that resulted in negotiated and a non-formal decision was whether a Unit Manager (at the same hierarchical level as a Nursing Supervisor) would be in an administrative and coordinating role. The Director of Nursing disagreed with the Project Director and insisted that a Unit Manager, at the same hierarchical level as a Head Nurse was essential if a Head Nurse was to develop a nursing role. The Project Director conceded this point. It will be recalled that in the Triad System, a physician, nurse and administrator would work as peers planning for and managing the delivery of total patient care in a specific area. The Project Director viewed the Nurse Coordinator as the administrator of nursing, responsible and accountable to the Director of Nursing Service for the standards of nursing care and the control of nursing staff. A physician responsible to a Chief of his Department was delegated to enact the role of physician in the Triad. Therefore, the Project Director believed there should be a parallel position for an administrative representative who would be responsible and accountable for the general management of the four wards and for the control of the Unit Managers and Ward Clerks. In order to achieve this goal the Project Director acted the role of

senior Unit Manager, named a Patient Care Administrator. Under the circumstances, it could be anticipated that the consequences of this agreement for the organization would be an eventual confrontation because it was essentially an informal agreement. It seems likely that eventually the informal establishment of the position for which there was no budget provision could be utilized by the Unit Managers as justifiable rationale for additional Patient Care Administrators in the event of an expansion of the Unit Management System.

Six months after they commenced working in the wards, Unit Managers ceased to be perceived as a threat by the majority of the nurses in the unit. The Head Nurses still said that additional Unit Managers should be employed at weekends and afternoons; they still did not believe that the nursing staff should be further reduced to pay for these Unit Managers and Ward Clerks. As one Head Nurse explained:

> If a Unit Manager is absent, a nurse can cope with his tasks, as well as nurse patients. If a nurse is absent a Unit Manager cannot fill this gap.[8]

The majority of the nurses in the four wards felt that additional Unit Managers and Ward Clerks would provide the nursing staff with the opportunity to provide more nursing care. The Head Nurses, however, even began to discuss the assistance they received from the Unit Managers. They said that they were pleased that responsibilities for "hotel functions" had been transferred to Unit Managers.

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[8] Interview with a Head Nurse, May 15, 1970.

Nevertheless, the basic concept of the Unit Management System -- a trend toward administrative control at the ward level -- remained a concern to the majority of nurses and physicians in most areas of the hospital. One nurse said that the introduction of Unit Managers indicated that Business Administration was attempting to take over Nursing Administration. She felt that only nurses were trained to be true Unit Managers.[9] Another nurse said that the innovation was exciting, and that Business Administration should assume its responsibilities and employ persons to perform managerial and non-nursing functions so that nurses could practice nursing care for which they had been trained. The physicians, in general, felt that patient care should be provided by an increased number of nurses directed by a Head Nurse who would also be responsible for the total management of a ward.

## Changes in the Roles of Team Leaders and Head Nurses: Phase III

When the Nurse Coordinator explained to the Head Nurses in the four wards that two "permanent" Team Leaders would be introduced in each ward, she said that it would enable the Head Nurses to become nurse specialists and teachers. With the implementation of positions for "permanent" Team Leaders, the Nurse Coordinator felt that Head Nurses

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[9] In an analysis about structurally induced problems that arouse anxiety among nursing leaders, Anselm Strauss suggests that the tension between administrative reality and perceptions of nurses is linked with the imagery of bedside care even in an era when nurses are increasingly forced by institutional developments into administrative roles away from the bedside. Anselm Strauss, "The Structure and Ideology of American Nursing," The Nursing Profession: Five Sociological Essays, Fred Davis (ed.) (New York: John Wiley and Sons, Inc., 1966), p. 98.

would be free to direct staff and patient education programs, give nursing care to patients, analyze nursing practices, and evaluate nursing performance.

The potential for the new role of the Team Leaders to provide more continuity in nursing care appealed to the four Head Nurses. They were enthusiastic about their new roles in which they would be responsible for planning, directing, implementing, and evaluating nursing care. Furthermore, they would develop roles as nurse specialists and teachers.

Assisted by the four Head Nurses, the Nurse Coordinator planned a program of orientation and instruction for Team Leaders. The phrase "permanent Team Leader" defined a nurse who would work permanently as a Team Leader. The traditional practice by which Head Nurses assigned student and graduate nurses on day shift to be Team Leaders, would be replaced by a system in which permanent Team Leaders would be assigned to manage the nursing care of about twenty patients. Members of the nursing team would be directed by and responsible to the Team Leaders for nursing care. The Nurse Coordinator said:

> Now that Ward Clerks and Unit Managers are responsible for the majority of the non-nursing tasks, professional nurses will spend more time with patients. In these four wards, permanent Team Leaders will be responsible for the nursing care plans for patients assigned to them; guidance and direction of team members; initiation of regular team conferences; receiving and giving change-of-shift patient reports; and accompanying physicians when they visit patients assigned to the Team Leaders' teams.[10]

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[10] Interview with the Nurse Coordinator, April 9, 1970.

The first problem in effecting the changes arose as a consequence of the proposed alterations in the role of the Head Nurses. Although the Nurse Coordinator interpreted the objectives of the new nursing system to both nursing and medical staff, initially the majority of the physicians and nurses did not understand the new, and often different responsibilities for Team Leaders and Head Nurses. Physicians and nurses believed that further alterations to the role of the Head Nurse would result in another upset in working relationships that were being stabilized after the introduction of Unit Managers.

The Nurse Coordinator also encountered resistance to the planned changes when she said that the creation of two positions for "permanent" Team Leaders in each of the four wards would require elimination of the positions of Assistant Charge Nurses. The nursing staff did not recognize that the purpose of "permanent" Team Leaders would be to provide a continuity of nursing care. They felt that there had always been Team Leaders[11] and that any nurse, including

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[11] Traditionally, the most common type of patient assignment is the functional method in which nurses are assigned specific functions or tasks. For example, one graduate nurse might be assigned to be the "medication nurse." A certified nursing aide might be assigned to "do the back care" and a nursing orderly might be assigned to bathe a number of male patients. Each nurse reports the completion of tasks to the Head Nurse. In 1965 the Director of Nursing at the University of Alberta Hospital attempted to introduce the team method with an emphasis upon comprehensive individualized patient assignments. A nursing team under the direction of a Team Leader who planned and directed nursing care was delegated responsibility for meeting patient nursing care needs. The objective of team nursing was to provide better care to patients, to better utilize the abilities of each member of the staff, and to prepare nurses to assume administrative responsibilities. For reasons such as shortage of staff, and resistance to change, team nursing was implemented successfully into only a few areas. Although a number of Charge Nurses did appoint Team Leaders, the concept of team nursing did not overcome traditional patterns of staff assignment.

a student nurse, could and did act as a Team Leader at a moment's notice. Furthermore, the majority of the nurses were concerned about the elimination of the positions of Assistant Charge Nurses which had, historically, provided the opportunity for a nurse to act as a Charge Nurse, earn increased income, and enjoy permanent day duty.

An Assistant Charge Nurse said she believed that she had been demoted. She said it was difficult for her to explain to physicians and other nurses that she had lost her position and now was a Team Leader. She expressed ambivalence about the proposed objectives of improving patient care that involved her in a loss of position. Nevertheless, she accepted the Nurse Coordinator's suggestion that she should become a Team Leader. She said she felt that whether they liked it or not, nurses were obligated to obey directives from superiors. In spite of the Nurse Coordinator's statement that she would not insist that a reluctant Assistant Charge Nurse should become a Team Leader, the Assistant Charge Nurse stated that she felt the only alternative was to leave the area.

### Conflicting Interests in Permanent Team Leaders

The Team Leaders expressed skepticism about the changes in the nursing roles. They stated they had applied for the position because it offered day duty. They pointed out that graduate nurses on afternoon and night shifts received a differential in salary because of the responsibility related to being in charge of a ward, but that the salaries of permanent Team Leaders were not increased.

According to one Team Leader, an organizational change that removed functions formerly the prerogative of Charge Nurses to Team Leaders and Unit Managers, would lead to confusion. Nevertheless, although critical of a system that was opposite to her values about the role of a nurse-in-charge of a ward, she said she accepted the administrative decision to implement the change because:

> . . . it does not matter what you believe. You go along with administration. It is their right to make decisions. As an employee, you carry out administrative directives.[12]

This statement implied that nurses, as Weberian theory proposes, complied with the Nurse Coordinator's instructions to change because they believed they should obey a superior's order. Their bureaucratic orientation indicates the degree to which organization structure directs change, and in this case suggests the degree to which the change was bureaucratically instituted.

At the same time as they complied with the Nurse Coordinator's instructions, the nurses freely expressed their opinions about the proposed changes, and the performances of each other. For example, when the Nurse Coordinator said the Team Leaders required considerable

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[12] Information collected during this study suggests that nurses believe that it is an administrative right to make decisions about organizational changes and expect that employees will accept changes. A frequent comment was: "He who pays the piper plays the tune." At the same time, they said it is their right to endeavour to attain their interests in spite of administrative decisions, provided it is acceptable to other nurses. Nurses concerned about elimination of Assistant Charge Nurse positions suggested that responsibilities assumed by Team Leaders should result in some form of merit pay or bonus. They said that with approval from the group they initiated enquiries related to action in the collective bargaining process.

guidance in organizing nursing assignments, determining nursing objectives, providing direction to nursing staff, and setting priorities related to planning nursing care, the Team Leaders said they were confronted by demanding situations. They pointed out that Head Nurses, Unit Managers, and the Nurse Coordinator and Project Director were also uncertain in their roles. The Team Leaders said that it seemed to them that it was not known precisely how people in each of the Unit Management System and Nursing System hierarchies should function and interrelate. Furthermore, they said that the staff, including the Project Director and Nurse Coordinator, were uncertain because they were in situations in which at the end of six months, an administrative decision might discontinue the program without the staff having any guarantee of future employment.

Although the Nurse Coordinator encouraged problem solving discussions related to this kind of issue, she did however disagree with many of the traditional routines in the four wards. She made a determined effort to remove routines that were obstacles to the development of changes in the roles of Team Leaders and Head Nurses. One of the most frequent arguments by the Team Leaders was that there was no time to participate in the conferences, clinics, and in-service programs directed by the Nurse Coordinator. When they protested that many established routines and procedures were being neglected because nurses had to attend meetings, the Nurse Coordinator decided if specific routines and procedures were necessary. If the Team Leaders were unsuccessful in arriving at solutions, the Nurse Coordinator's decision directed the course of events. Frequently, she abolished

a routine or procedure because it was no longer functional.

For example, on one ward a "medication nurse" prepared and administered medications for every patient. When the Head Nurse and Nurse Coordinator attempted to alter this routine so that each nurse could assume responsibility for administering medications to her patients, the Team Leaders said lack of space and numbers of medications required adherence to the well-established medication routine. They said the implementation of the change in the procedure would require additional nursing staff.

The Nurse Coordinator initiated a study of activities related to the medication nurse's functions. The findings of the study demonstrated the traditional routine was more time consuming and contributed less to the continuity of nursing care than did the proposed method. The Team Leaders were directed to discontinue the assignment of one nurse to be the "medication nurse." In this instance, the Team Leaders' negotiations influenced the Nurse Coordinator to reappraise and review the traditional routine and consequently to institute the change she considered to be necessary. She expected her subordinates to comply with her instructions and they did so.

The control of administrative functions, such as nursing assignments, implementation of procedures and routines, and training programs gave the Nurse Coordinator considerable power over the nursing staff. Although the Team Leaders did argue about changes in routines and procedures and although they did engage in bargaining to affect their own activities (such as the method of administering

medications), authority rested with the Nurse Coordinator. When she issued instructions, attempts by nurses to bargain were discontinued and the nursing staff complied with her wishes. This aspect of bureaucratization demonstrates that this group conformed to the Weberian type of "legal" authority.[13]

## Conflicting Expectation of the Head Nurses

From the onset of the appointment of the Team Leaders, the Head Nurses complied with the Nurse Coordinator's instructions to give many tasks formerly assigned to Head Nurses to the Team Leaders. Although the transfer of responsibilities and the focus on specific tasks to be performed by Team Leaders over-simplified the complexities of organizational life in the four wards, the establishment of Team Leaders was achieved and team nursing was initiated. But the changes generated tension.

The removal of tasks from the Head Nurses seemed to increase the work satisfaction of the Team Leaders but the reorganization of the nursing functions began to concern the Head Nurses. They complained that the Head Nurses gave tasks away without receiving tasks they could accomplish in return. Furthermore, the conflict between

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[13] Legal authority is legitimated by a belief in the requirement to follow directions originating from an office superior to one's own. In Weber's view, beliefs in the legitimacy of the system can contribute to the stability of the authority relationship.

the demands of the nursing staff and physicians, and the demands of the Team Leaders and Unit Managers, increased the anxiety of the Head Nurse.

While physicians and nursing staff continued to expect the Head Nurse to behave in the traditional role, the Unit Manager and Team Leaders expected her not to interfere with their newly acquired activities. The majority of the nursing staff were not accustomed to the Head Nurse giving patient care, analyzing nursing practices and directing changes in care on evening and night shifts as well as on day shift, so they negotiated in order to retain control of their working arrangements. For example, when one Head Nurse attempted to work with nurses and aides, they said they did not want to take her from her work at the desk.

The Head Nurses' hours of work reduced their ability to control and coordinate communications. As they did not regularly attend shift reports, write nursing care plans, or remain at the desk, they were not in constant contact with physicians, nursing staff and other members. Both medical and nursing staff began to take problems related to patient care to Team Leaders. This led to a change in relationships and a transfer of the influence associated with the role of the Head Nurse, to Team Leaders and the Unit Manager. Although they appreciated the assistance of the Team Leaders and the Unit Manager, the Head Nurses still had difficulty in relinquishing the responsibility attached to former activities. Team Leaders and the Unit Managers commenced to bargain with the Head Nurses. They stated that

there must be agreement that they would be responsible for activities officially delegated to them. They pointed out that initially the Head Nurses had agreed to transfer activities to them in exchange for changes in their roles.

Stress related to confusion about the new role is illustrated in the following explanation by a Head Nurse. She said:

> For years I had complained that clerical tasks and the desk kept me from patients and from giving nursing care. I had resented the fact that we did not practice team nursing. When the project commenced I assisted the Nurse Coordinator to explain the concepts of team nursing and of the Unit Management System to the staff. I taught the Nursing Orderly to feel comfortable in his role as a team member, and helped Team Leaders to delegate, plan and organize. I was delighted when Team Leaders began to perform as leaders -- to manage nursing care, organize and supervise staff -- according to the principles of management. The Ward Clerk was capable and reliable, and the Unit Manager learned to function without my support. When I realized that I had given away the functions that had kept me busy, it was a desolate feeling. No longer did physicians seek my assistance. Physicians and others sought assistance from Team Leaders. Ward Clerks and the Unit Manager worked together. I seldom spoke to people in service departments because the Unit Manager was responsible for supplies and services and for coordinating maintenance and housekeeping activities. According to the job description that I had helped to write, I was responsible for patient care in the area, for control of the management of nursing care and nursing personnel, and for teaching. This meant working with patients and staff at the bedside, but the members of the nursing staff were uncomfortable when I was away from the desk. When I attempted to assist nurses or Certified Nursing Aides to give nursing care they said that they did not want to take me from my work; they appeared to be almost on the defensive because I was interfering with their work.[14]

The first few months after the introduction of Team Leaders there were complaints by the physicians about the ambiguity they felt

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[14] Interview with a Head Nurse, May 12, 1970.

surrounded the role of a Head Nurse, and the fact that they were expected to have a Team Leader instead of a Head Nurse accompany them when they visited patients. The physicians were critical of the change. They said that a Team Leader knew only about the patients assigned to her team; physicians resented being asked to visit one patient accompanied by one Team Leader, and then to acquire information about another patient, having to seek another Team Leader.

It took the Team Leaders about three months to adjust to their new responsibilities. They settled into stable working relationships with physicians, nursing staff and Unit Managers. The Head Nurses became aware that the physicians also were adjusting to the changes and the growing esteem of the physicians for the Team Leaders increased the Head Nurses' anxiety. This was emphasized when a physician, who at first had been critical about Team Leaders accompanying him instead of the Head Nurse said:

> These Team Leaders are like the Charge Nurses I thought belonged to the past. They know about my patients because they look after patients. They give excellent reports about patients' progress. The Head Nurse -- if I do see her -- has to check with Team Leaders to find out specific details about a patient.[15]

The Head Nurses recognized then that an aura that had been attached to their traditional role had been transferred to the Team Leaders. Aware that their relationships with physicians, nurses and patients were changing, they began to attempt to return to performing in the traditional way. For example, one Head Nurse accompanied

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[15] Interview with a Physician, May 14, 1970.

physicians when they visited patients. She checked orders and wrote nursing care plans. Another Head Nurse remained at the desk ignoring the fact that the Unit Manager had trained the Ward Clerk to perform additional clerical activities.

## Negotiative Activities

A bureaucratic decision introducing "permanent" Team Leaders resulted in the four Head Nurses losing much of their influence and power. It led to negotiative activity that had consequences for the nursing structure in the four wards and also for the future careers of the four Head Nurses and the Nurse Coordinator.

The attempts by the Head Nurses to stabilize their positions vis-à-vis the Team Leaders led to disagreements. As a consequence, the Team Leaders requested meetings with the Nurse Coordinator and the Head Nurses. The discussions revolved around the content, conditions, premises and the grounds within and on which the Team Leaders and Head Nurses would perform according to agreements in the planning phase.

The basic issue involved factors of status and power and was about the expansion of control by the Team Leaders into areas formerly under the control of the Head Nurses. The Head Nurses emphasized that they had given away tasks and responsibilities without receiving tasks they could accomplish in return. They now said that because the Team Leaders were acting like Head Nurses, the Head Nurses should be responsible for activities being performed by the Nurse Coordinator. They also felt that a Head Nurse should be responsible for two wards rather

than one ward in a system that employed Unit Managers.

The Team Leaders argued that the Head Nurses still retained many activities now officially assigned to Team Leaders and Unit Managers. The Head Nurses were not keeping to the bargain made during the planning phase. The Team Leaders said that the Head Nurses, freed of many managerial and nursing functions by Unit Managers and Team Leaders had time to teach and evaluate nursing staff and nursing practice and should do so. In addition, Head Nurses should be more involved in meeting the social and emotional needs of patients; the Team Leaders felt that neither they nor the nursing staff had the ability nor the time often to provide this kind of patient care. The Team Leaders pointed out that during the planning phase the Head Nurses had agreed to a reorganization of nursing activities and to the establishment of new roles for themselves and permanent Team Leaders.

In the tacit bargaining about this point, the concerns of the Head Nurses related to their ability to perform in the new role became explicit. Specifically, it depended not only on their attitudes; they felt they did not have the skills essential to either develop or perform the prescribed role of a "specialist" and a "teacher." One Head Nurse said that the Head Nurses were so busy delegating tasks to Team Leaders, they had not planned what they would do when these tasks were transferred.

Workshops had been established for the Head Nurses to plan for the development of their new role. The Nurse Coordinator, busy

with guiding and directing Team Leaders, and liaising with the Project Director, felt that Head Nurses should define the activities involved and the necessary action to establish the new role. The negotiations revealed that the Head Nurses, accustomed to their traditional role, were unable to plan the development of a different role. What was more, the fact that the physicians looked upon the Team Leaders as their "little Head Nurses" indicated to the Head Nurses that the changes were perceived by physicians as a loss of status for the Head Nurses. The idea that Head Nurses would support the social and psychological needs of patients was said to require acceptance by physicians. An implication of the concern of a Head Nurse that many physicians seem to be interested only in technical nursing functions was observed when a physician commented:

> I haven't time to listen to a nurse who is primarily interested in social and psychological needs of patients. I need accurate information about drainage, elimination, removal of tubes, input and output.[16]

From the beginning of the negotiations, the Team Leaders had an effective means of control because they were able to specify the kinds of activities for which they were not responsible and activities for which they were. They could establish and validate their roles by referring to these activities. On the other hand, the Head Nurses were unable to identify for themselves, or others, the activities related to their new roles. Their bargaining power was therefore minimal. In addition, tasks emphasized by the physicians to be important were

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[16] Interview with a Physician, August 15, 1970.

performed by Team Leaders.[17]

At this point, it was not only necessary that the Nurse Coordinator make a decision about the nursing structure in the four wards, she had to work with the Team Leaders and Head Nurses to attempt to achieve their expectations or her own. She discussed the situation with the Project Director and they tried to analyze what was occurring in the four wards. As a result, the Nurse Coordinator and Project Director concluded, in July 1970, that the role of a Head Nurse in the four wards was anachronistic because there were Unit Managers and "permanent" Team Leaders.

The Nurse Coordinator utilized again the precedent of Head Nurses participating in planning for further changes. In meetings arranged by the Nurse Coordinator, the Head Nurses became involved in discussions about a further modification of the nursing structure in the four wards. This provided the Nurse Coordinator with support for alterations in the nursing system in the four wards. It also tended to reduce the anxiety of the Head Nurses. They began to see that although the traditional role would be eliminated, the role of

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[17] The relationship between organizational goals and power structures has been studied by Charles Perrow who hypothesizes that, over the long run, an organization will be controlled by those individuals or groups who perform the most difficult and critical tasks. Perrow states that the importance of a particular task area depends upon the technology employed, the market for the goods or services, and the stage of growth of the organization. He says that an emphasis upon any one (or combination of two or more) will tend to give controlling power to the group that fulfills the tasks. Charles Perrow, "Goals and Power Structure," in The Hospital in Modern Society, Eliot Friedson (ed.) (London: The Free Press of Glencoe, The Macmillan Co., 1963), p. 113.

a "permanent" Team Leader had influence and status. Furthermore, the Nurse Coordinator and the Head Nurses discussed the feasibility that a senior nurse -- or a Head Nurse -- would be responsible for the coordination of nursing care for a number of wards. It should be noted that the involvement of the Head Nurses enabled the Nurse Coordinator to plan for further changes. The Head Nurses agreed to the changes that both the Nurse Coordinator and the Project Director planned should be implemented.

August, 1970, was the turning point in the history of the "permanent" Team Leader-Head Nurse conflict. The question that was raised then was not whether the "permanent" Team Leaders should continue to be "little Head Nurses." The issue was whether the nursing structure in the four wards would be modified. Should there be a Nurse Coordinator? Or, should Team Leaders develop roles to include the responsibilities of a nurse specialist and teacher and should a Head Nurse assume the nursing administrative responsibilities for two wards thus eliminating the need for a Nurse Coordinator?

From the viewpoint of the Team Leaders and the Head Nurses, one senior nurse -- whatever the title -- could be responsible for the nursing administration for two wards, and coordinate the nursing activities in accordance with medical direction and nursing policies. They felt that the Team Leaders -- "the little Head Nurses" -- would be the specialists in nursing care and the senior nurse would be involved in assisting Team Leaders and directing the management of nursing care in the two wards.

They also felt that the senior nurse should have preparation or experience in the special nursing care required in the area. In an interview, a Head Nurse said:

> I don't think we decided that there is not a role for a Head Nurse. We decided that the nurse, in the position of a Head Nurse, would be better utilized with more specific responsibilities. The "permanent" Team Leaders have specific direct care functions. There should be a senior nurse who manages the total nursing care, directs teaching programs for staff and patients, and with the Team Leaders, evaluates the performances of nursing staff. As I see it, the Nurse Coordinator -- aside from her present work in directing this program -- could coordinate administrative aspects of nursing for a much larger area than this one. The administration of nursing care in two wards should be delegated to a nurse -- a Head Nurse -- if she has the preparation or experience.[18]

In another interview, a second Head Nurse commented:

> My family tells me I am doing myself out of a job but I cannot work as a Head Nurse in this system. I would be happy to work as a "permanent" Team Leader even if it means a decrease in salary. It is like the old Charge Nurse position without the clerical work.[19]

Probably the most relevant statement made during the discussions between the permanent Team Leaders and the Head Nurses was:

> The creation of positions of Unit Managers has the potential to enable nurses to perform as professional nurses, but most nurses are not ready and, generally speaking, physicians are not ready for this kind of nurse. The real issue is about the ability of nurses to carry out independent functions and that they are permitted to do so. The Nurse Coordinator's objective is to devise a system which will enable nurses to practice nursing care and make independent nursing decisions. If the introduction of

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[18] Interview with a Head Nurse, September 10, 1970.

[19] Interview with a Head Nurse, September 15, 1970.

> the Unit Management System does not also have a Nursing System that is parallel to it so that patient care activities are integrated, then it is a waste of money. It also adds more kinds of workers around patients.[20]

While it is true that the informal agreements between Team Leaders and Head Nurses about the modifications in the nursing structure, contributed to alterations in the formal directives and the program for changes in the four wards, the bureaucratic organizational structure determined the degree to which further change would be made. The Nurse Coordinator was influenced by the values of both nursing staff and physicians about the traditional role of a Head Nurse. She realized that the organizational change had destroyed the positions for the four Head Nurses. She also recognized that in place of the traditional role of a Head Nurse on each ward, there had evolved positions for two "little Head Nurses" with roles in the management of nursing care rather than in the management of total patient care services. It was also apparent that the time was not ready for nurses to operate exclusively as nurse specialists and teachers.

As a consequence of the agreements that were arrived at through negotiations between Team Leaders and Head Nurses, and the Nurse Coordinator, the Nurse Coordinator submitted to the Administrative Committee, recommendations for the elimination of the positions of Nurse Coordinator and Head Nurses in the four wards (see Chart V). Suggesting that a Nursing Supervisor would be appointed

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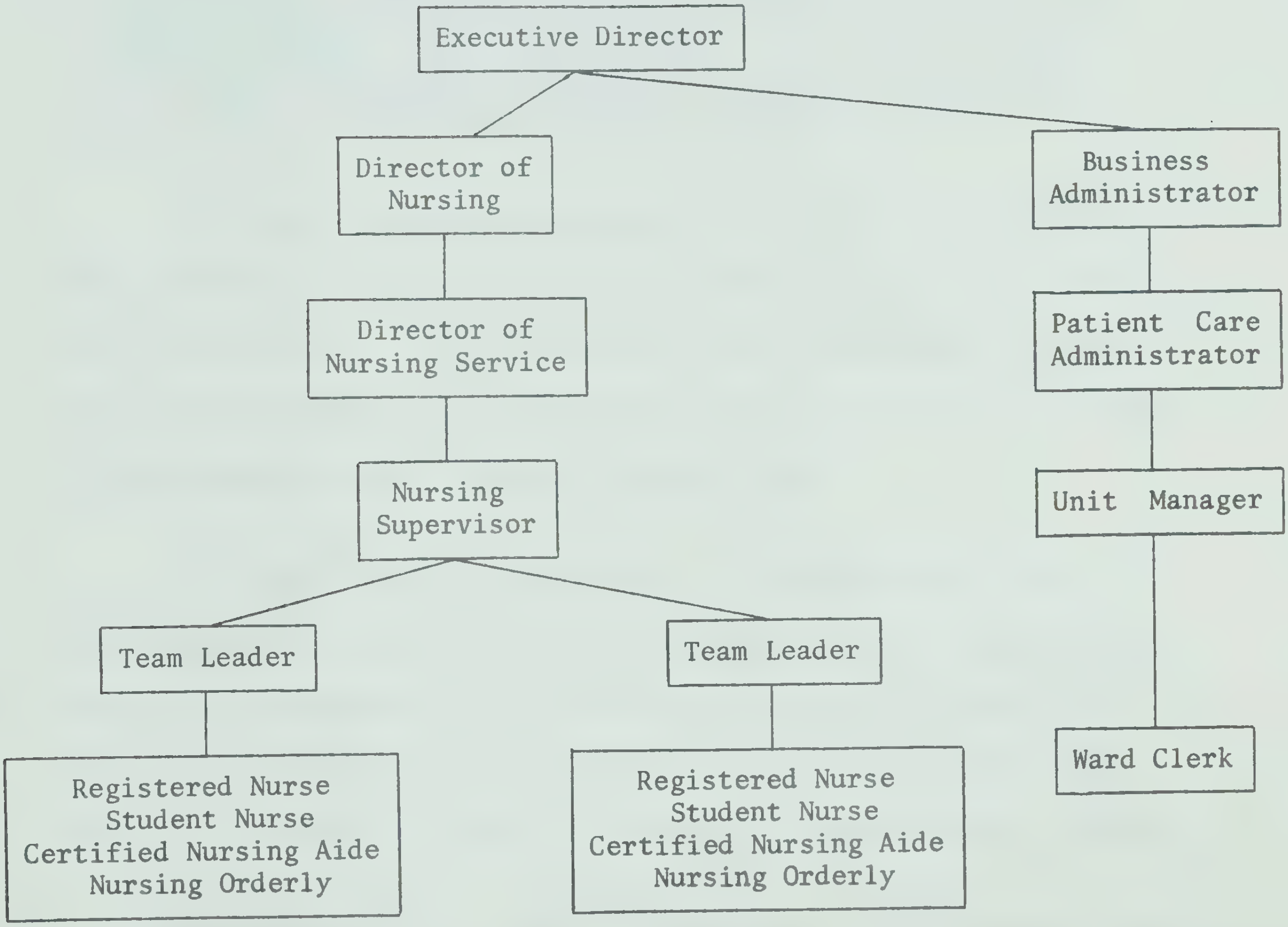
[20] Interview with a permanent Team Leader, October 5, 1970.

CHART V

Organization Chart
NURSING SERVICE UNIT MANAGEMENT



to be responsible for two wards, the Nurse Coordinator stated:

> Each Supervisor would be accountable for an area with approximately seventy patients. Her job description would include some of the nursing education and nursing management functions which have previously been assigned to the Head Nurse, and nursing administrative functions previously the responsibility of the Nurse Coordinator. The Supervisor would be the nursing expert with in-depth knowledge of the nursing specialty and have responsibility for the over-all management of nursing care and nursing personnel within the two wards. She would be responsible for the on-going development of permanent Team Leaders and in-service education programs for nursing staff.[21]

The Nurse Coordinator recommended that a Nursing Supervisor would coordinate long-term planning for services with the Unit Managers and the Team Leaders. The Team Leaders would be delegated responsibility for the routine management of patients, direction of activities of team members and also teaching nursing staff.[22]

As Strauss states, the personal and professional values of individuals and groups set limits to the ways in which organizational changes were implemented. To a considerable degree the negotiative activities of Team Leaders, Head Nurses and the Nurse Coordinator, reflect the essence of Strauss' explanation of organizational change.

Consequently, as a result of negotiations, Team Leaders, Head Nurses and the Nurse Coordinator reached understandings about the roles of nurses in a ward where there was a Unit Management System. They agreed that if a Nursing Supervisor and Team Leaders managed

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[21] Unit Management Project Final Report, October 1970, p. 6.

[22] Ibid.

nursing care, and if a Unit Manager was employed, there was not a role for the Head Nurse. These informal agreements, as a result of informal negotiations, had considerable influence. They generated further negotiations within the official hierarchy with the consequence that an official directive eventually modified the nursing structure. The position of Head Nurse was eliminated.

# CHAPTER V

# SUMMARY, CONCLUSIONS AND OBSERVATIONS

A case study of the implementation of a Unit Management System in four wards at the University of Alberta Hospital was carried out in an attempt to examine the complementarity of the theories of Max Weber and of Anselm Strauss.

The findings support the thesis that the two theories contribute more to an understanding of organizational change than would be provided by only one of the theories by itself. In effect, change emanates from two sources: "administrative position," as described by Max Weber, and "negotiated order" as proposed by Anselm Strauss.

The study focuses attention on the dynamics of change in a hospital where a Unit Management System was introduced. Throughout the period under study, the relationships existing between patterns of both bureaucratic and negotiative behavior overlapped; however, when viewed together they show how the Weberian and Straussian theories interact as complement to each other in explaining organizational change.

First, in accordance with Strauss' concept, the informal negotiations of nurses with hospital administrators about the desirability of changes in the roles of nurses were important in influencing members of the Administrative Committee to formally recommend that a Unit Management System would be introduced.[1]

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[1] Above, Chapter III, p. 44.

Secondly, in the Weberian tradition, bureaucratic processes protected the hospital against the pressures of negotiative processes. Official procedures and formal mechanisms set limits within which negotiative processes were established. For example, the change was not implemented until the Executive Director authorized the introduction of the new system and appointed a Project Director and a Nurse Coordinator. Bureaucratic methods were used to appoint the two Unit Managers and to institute changes in the roles of Team Leaders and Head Nurses. The Project Director and Nurse Coordinator briefed nurses and physicians about the Unit Management System and trained the staff to perform specific activities. Job descriptions were distributed.[2] Furthermore, the bureaucratic orientation of the nursing staff -- to the extent that they accept and value the legitimacy of the authority structure -- indicated the degree to which the changes would be bureaucratically instituted.

The fact that the Unit Management System was formally established did not mean that it achieved its initial objectives. As Strauss predicts, the bureaucratic methods that exercise control -- such as hierarchical authority -- led to conflict. It is demonstrated in Chapter IV how conflict led to bargaining, in which agreements were negotiated between each group of nurses, and between Head Nurses and Unit Managers for the exchange of activities and functions. The data also indicates how informal compromises and agreements were negotiated between nurses and Unit Managers and officials in the administrative

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[2] Above, Chapter III, p. 47, and Chapter IV, pp. 48-49, 53-57.

hierarchy and, also how agreements were reviewed and withdrawn.[3]

In keeping with the concept of Strauss, the earlier objectives of the Unit Management System were modified. The alteration of the functions of nurses influenced previous values about the roles of nurses and, in turn, these changes in values affected administrative objectives. New patterns of activities and interaction were, in effect, modifications of the initial administrative arrangements. The data indicate how the interaction between both bureaucratic processes and negotiative processes had an impact on the nursing system.

Not all changes emerged as a result of negotiation; on the contrary, negotiations and therefore certain changes were avoided frequently because of the bureaucratic form of the administrative structure in which there was a compliance with orders of hierarchical superiors. The Project Director and Nurse Coordinator for example, made formal decisions to state and discuss issues with the staff affected by the change. Furthermore, formal policies and rules directed the change. This was highlighted early in the study when the nursing staff, unable to strike a bargain to provide more nursing care accepted the fact that there would be a reduction in the nursing staff. The Executive Director's decision about the source of the salaries of Unit Managers was not influenced by the negotiative activities of the nursing staff.[4]

Finally, the analysis of the processes of change during the

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[3] Above, Chapter IV, pp. 59-68, 81-83.

[4] Above, Chapter IV, p. 60, pp. 74-76, 83-84.

period of the study shows the influence of bureaucratic structures upon negotiative behavior and vice versa. This is exemplified by the data on the conduct of nurses who became involved in negotiations in order both to accomplish their individual purposes and to work in wards where Unit Managers were established. It was shown how ideology, hierarchical position and training affected negotiations; and, how informal negotiated agreements between groups of nurses generated further negotiations with the formal administration of the hospital.[5]

The flexibility of the bureaucratic form of organization allowed members to negotiate and to arrive at compromises with other members; however, it should be noted that in the last analysis any negotiated agreements reached by professional nurses were subjected to the bureaucratic administrative structure which determined the degree to which further change would be made.

The interdependence between the bureaucratic elements and the negotiative processes illustrates the complementarity of the theories of Weber and of Strauss in explaining how organizational change is accomplished.

## Concluding Observations

The limitations in generalizing from a single case were recognized. The size of the population studied and the fact that issues may have occurred at this teaching hospital that may not occur in other

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[5] Above, Chapter IV, pp. 85-86.

hospitals, cause difficulties in generalizing from one case. Furthermore, additional facets to the implementation of the Unit Management System still require exploration. The issue related to whether or not decentralization of nursing care services would be implemented, was not investigated. Nevertheless, an advantage of a single case study is that the investigation focuses attention on the underlying processes operating within the system. One may generalize from the case using variations that occur within the system over a period of time or between different parts of the system; therefore, one can go behind the overall generalization to the process through which it was presumed to exist.[6]

It is suggested that the study provides useful insights for hospital administrators, specifically in the area of reorganization of administrative structures, by demonstrating and clarifying the utility of organizational theory in understanding the dynamics of change in organizations. The study is of theoretical interest in that it analyzes the change aspect of two theoretical approaches and looks at complementary dimensions of the theories. Furthermore, it indicates useful direction for further studies related to the implementation of change in hospitals.

Such studies might deal in more depth with the role that "negotiated order" plays in the operation of the bureaucratic form of organization, and with the significance of formal structures, such as administrative committees. It is suggested that conclusions obtained

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[6] Seymour Lipset, M. Trow, and J.S. Coleman. Unit Democracy (New York: Doubleday and Co., 1962), pp. 426-427.

from such studies would provide a basis for obtaining a greater degree of insight into the role played by informal negotiations in generating administrative policies that are an effective compromise of the various interests involved. The studies may provide hospital personnel with a medium to become better acquainted with their organizations, and to perceive the significance of organizational behavior with respect to implementing change.

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